ANNEX

Joint Action on Mental Health and Well-being

MENTAL HEALTH AT THE WORKPLACE

Situation analysis and recommendations for action

TECHNICAL INFO

MENTAL HEALTH AT THE WORKPLACE

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AUSTRIA

Joint Action on Mental Health and Well-being: Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report:
SWOT-analysis Austria

1. Introduction

The SWOT analysis to support mental well-being in the company was carried as part of the "Mental Health and Well-being" joint action. Members of the Austrian Network for Workplace Health Promotion (www.netzwerk-bgf.at) were consulted during July and August 2013.

The following results are based on the feedback from six network members.

2. The Austrian Network for Workplace Health Promotion

Statutory health insurers have an important role in the Austrian Network for Workplace Health Promotion (Österreichischen Netzwerk für Betriebliche Gesundheitsförderung (ÖNBGF)). The Coordination Office of the network is based at the Upper Austrian Regional Public Health Insurance location.

Supporting partners within the Austrian Network for Workplace Health Promotion are the Austrian Federal Chamber of Labour, Austrian Chamber of Commerce, Austrian Federation of Trade Unions and the Austrian Association of Industry. The active cooperation of the four social partners underlines the usefulness of workplace health promotion for employees and facilitates transferring health promotion principles into the workplace.

The regional offices are managed mainly by health insurance funds, especially in the provinces of Burgenland (Burgenland regional health insurance), Lower Austria (Lower Austria Health Insurance), Vienna (Vienna Health Insurance), Steiermark (Styrian Health Insurance), Carinthia (the Carinthian regional health insurance), Salzburg (Salzburg GKK) and Tyrol (Tyrolean Regional Health Insurance). Only the Vorarlberg regional office is run by an organisation commissioned by Vorarlberg Health Insurance (Fund for a Healthy Vorarlberg). The umbrella organisation of public health insurance on the network also participates with the main Austrian Social Security Institutions. The Insurance Institute for Railways and Mining, the Workers' Compensation Board, the Social Security Institution for Trade and Industry and the Insurance Institute of public employees have also joined the network.

The Austrian Network for Workplace Health Promotion has the following national and regional goals:

- To establish an Austrian-wide common understanding and develop its progression

- To provide skilled points of contact for companies and stakeholders

- To establish the network as a hub for Workplace Health Promotion in Austria

- To ensure a high quality implementation of Workplace Health Promotion in Austrian companies

- To use the information exchange between the European and Austrian network and to use the potential for innovation and continuous development

Today's state of development of Workplace Health Promotion in Austria is mainly thanks to ÖNBGF's driving force. On a European level, the general status of development of Workplace Health Promotion in Austria and the general skill level of the economic players is seen as exemplary.

3. Quality control by the Austrian Network for Workplace Health Promotion

In the following you will find a short explanation of the ÖNBGF's quality control system to contribute to a better understanding of workplace health. The most important function or task of the network is, however, the quality control of Workplace Health Promotion activities.

ÖNBGF's quality control system consists of three levels.

The Workplace Health Promotion Charter is the first level and is a symbolic commitment by the company's management to ensure the health of their employees. No actual steps for implementation are expected at this level.

Illustration 2: The Workplace Health Promotion-Quality Seal

The Workplace Health Promotion-Quality Seal recognizes companies who carried out their Workplace Health Promotion activities successfully and in a structured manner. This comes in the form of a bonus for "Good Practice" projects. The Workplace Health Promotion-Prize is the third level and awards "Best Practice" projects from the pool of Quality Seal recipients. These are exemplary projects with outstanding project elements.

Although the Workplace Health Promotion Quality Seal is only one element of ÖNBGF's entire quality control system, it has become the central instrument over the years. The Workplace Health Promotion Quality Seal has a great publicity effect, is very popular with the companies and ultimately helps to connect and establish the identity of the entire network. This is the main reason why the Quality Seal and its award should be examined carefully and demonstrate a high degree of transparency, objectivity, communication and stability.

4. Workplace Health Promotion and the promotion of mental well-being

Right from the start, any workplace health promotion projects have followed a holistic salutogenetic approach. Therefore, the promotion of mental well-being was and is usually the explicit or implicit goal. On the one hand, the increasing de-stigmatization of individual psychological problems has led to an increase in mental illness and the willingness to report it, but on the other hand the need and willingness to accept mental health issues lead to an increase in promoting mental health in general and in the workplace setting in particular.

This fact is reflected very clearly in the projects that are offered and carried out by the Regional and Service Centres of ÖNBGF. Initial motivation to implement projects, objectives and actions often reflects increasingly more recognized deficiencies in the area of mental health. In this sense, the ÖNBGF sees its task as providing appropriate answers and programmes for inquiring businesses. This has been intensively implemented since 2011.

5. Strengths and weaknesses in relation to the promotion of mental health in the workplace

5.1. Strengths

The strengths of the promotion of mental health in the context of WHP/WHM projects based on the feedback is founded on three pillars.

1. Clear principles in terms of the Luxembourg Declaration

2. Austria-wide basic structure of the projects and uniform process logic

3. ÖNBGF's quality assurance system

Ad 1: The interviewed members of the ÖNBGF share the view that the starting point for a comprehensive mental health promotion can be determined by compliance with the basic principles of the Luxembourg Declaration: 1) integration 2) participation 3) holistic view of health 4) systematic approach 5) gender mainstreaming. These established and recognized principles can be described as a strength of workplace health promotion; these are the foundation for general health as well as the promotion of mental health.

Ad 2: The WHP in Austria looks back on 20 years of development. During this time, a core process has emerged which is supported by all network members. Although federal differences and variations by individual programmes and offerings may occur at times, the basic structure is overall the same. Thus a uniform understanding of workplace health promotion has been promoted and achieved all over Austria.

Ad 3: Since the mid-nineties of the 20th Century, workplace health promotion witnessed a gradual increase in importance in German-speaking countries. Despite complementary and partly competing streams (corporate integration management or evaluation of work-related mental strain), there has been no change in this circumstance to this day. The associated dynamics of this field of activity and the resulting services, programmes and policies can hardly be overlooked today. An exhaustive evaluation of the quality is only possible to a certain extent due to the actual quantity of programmes. The European Network for Workplace Health Promotion (ENWHP) has recognized this ambivalent development quite early and provided a rough guide within the Luxembourg Declaration. The quality criteria are described too simply in order to be used as a direct tool for quality control whilst they are possibly too powerful and widespread in their significance and evidence to be negated.

The ÖNBGF players have developed a three-step quality assurance system in 2005 which is essentially still in use to this day. As per February 2014, 1076 companies have signed the WHP Charter; 467 companies received the BGF Quality Seal. All in all, listed foundations are only indirectly related to the promotion of mental health, but they show that WHP is well

implemented and developed in Austria. A healthy and functional foundation is the irrevocable condition that mental health is not only promoted but also is and can be supported through holistic WHP projects. The strengthening of WHP in Austria is thus equated with strengthening mental health promotion in the context of WHP BGM projects.

Nevertheless, it is necessary for Austria to determine benchmarking issues with regards to operational integration management and to evaluate work-related mental strains. An efficient use of synergies between these programmes, measures and developments is hardly possible; a tangible user/inward-oriented definition is not available.

5.2. Weaknesses
Weaknesses regarding supporting mental well-being stated by those questioned are: the lack of a consensus based, clear definition of mental well-being and mental health promotion. Operating policies often leave the unanswered and vague question as to which measurement criteria can be classed as an intervention to promote mental well-being. This often results in a poor declaration of the measures and therefore the WHP underperforms.

Another deficit noted was the lack of legal framework or obligation of WHP in Austria. This means that WHP measures have less priority in businesses in comparison to other operational interventions which have a legal status. Related to this is the already noted shortcoming that unanimous benchmarking criteria for legally binding evaluation of work-related mental stress are indeed present but have not been internalized in the perception of relevant stakeholders, particularly in the perception of the companies. Similarly, it is noted that the ruling in the WHP principle of voluntary action is not considered as a deficit by all respondents.

Another weakness relates to the quality assurance of providers in the WHP sector. WHP measures may be offered independently of relevant training and certifications. This leads, among other things, to dubious, non-quality assured services and measures which are classed as WHP.

The last reference demonstrated a fundamental weakness of WHP. WHP focuses on the group or company level. It tries to increase the level of health in general. A consideration of the individual level takes place only partially.

6. Opportunities and risks with regard to the promotion of mental health in the workplace

6.1. Opportunities
Respondents sometimes also identify weaknesses as opportunities. In this sense, the use of synergies is mentioned regarding the evaluation of work-related mental strains. If an agreement on a parallel implementation of WHP and the evaluation of work-related mental strain could be achieved, both processes would become increasingly attractive for businesses. Although the intended objectives and emphasis in the process and in the implementation have differences on the voluntary concept of workplace health promotion, it is still possible to see links for interaction of the stakeholders for evaluation, and WHP appears promising, useful and important .

Another opportunity concerns social interaction with mental health and mental illness. Without a doubt, we are currently experiencing a phase where the stigma of mental illness is removed. This paves the way for the implementation of effective and targeted interventions and provides the basis for setting-oriented measures to promote mental health.

In this context, a further opportunity was stated to promote mental health in the context of workplace health. Here, too, a weakness has been declared as an opportunity. The previously mentioned variety of vendors thus not only means difficult quality assurance, but at the same time offers a wide range of programmes.

6.2. Risks
The potential shortage of resources is recognized as a risk. This would be a danger to both the social security side and to businesses. Although there are currently no immediate threat indicators for this, these are potential scenarios which could occur at any time.

A lack of or unsuitable networking is also seen as a risk. Psychosocial health is an interdisciplinary issue and therefore concerns a range of stakeholders. The questioned network members consider only an interdisciplinary approach as suitable to achieve the goals.

Furthermore, the exclusivity of WHP within the health and workplace market is currently questioned. There is the evaluation of work-related mental stress as a statutory obligation that has great similarities to WHP in terms of sequence or process. Although there are distinct differences, the companies involved might see this bluntly as an academic finesse.

In defining the evaluation of work-related mental stress, other obligations and programmes seem to be advisable. The perception that WHP is in comparison a "freestyle" or additional solution and therefore a "less important" offer should be avoided.

The WHP quality control is considered as an additional risk or challenge. It is important to continue to adhere to the guiding principle of the Luxembourg Declaration.

7. Recommendations to improve the protection and promotion of health in the workplace

The recommendations can be based on the previous states and are described as follows:

1. Consistent implementation of WHP and BGM

2. Development of quality-assured workplace health promotion projects with a greater focus on mental health

3. True exclusivity and unique features of the WHP

4. Increased awareness of mental health promotion in the workplace setting

8. Opportunities and threats in terms of supporting employees with mental health problems

8.1. Strengths

Workplace health promotion has theoretical and operational boundaries in relation to the promotion of individual mental health. At all events, however, WHP is considered to form the basis for company integration management. This has to be declared as a strength of WHP.

8.2. Weaknesses

The fact that mental health is still partially considered a taboo has to be considered a weakness. Whilst there is an increasing demystification and de-stigmatization in urban areas, this is not always the case in rural areas. In this respect, the subject must always be treated with a sensibility that can at times become an obstacle to health promotion and prevention programmes.

A WHP-specific weakness is the fact that adequate and resource-saving tools and measures for small and medium-sized enterprises are in place but are inadequate due to in-house resources not always being available. According to the opinion of respondents there is a lack of simple, resource-saving tools which are also efficient.

9. Opportunities and threats in terms of supporting employees with mental health problems

9.1. Opportunities

A basic theoretical approach of embedding health promotion and disease prevention across the entire spectrum of health services opens a perspective according to which successful risk management, health promotion, prevention and curative care and rehabilitation have to be considered as integrative solutions. In this respect there is a current trend in Austria whereby workplace health promotion is no longer used as an isolated strategy, but is intended as an integrative model. Ultimately, it is about the question of whether the structures, processes and know-how of WHP can be applied or transferred for secondary and tertiary preventive concerns. At all events, the integrability of WHP in general and specifically WHP tools have to be evaluated and used if necessary.

So far, the health theoretical discourse was characterized by a linear model, which can be outlined as follows:
To consider (company) health promotion and disease prevention as preceding sub-processes for curative treatment is outdated and implies that the entire health-related potential of existing patients could not be exhausted. So it should be quite possible, for example, that people with chronic physical or mental illness benefit from WHP programmes as part of their target group orientation. At all events, the jurisdiction of the structures created in the context of WHP should be extended to such persons or subjects. WHP does not forbid the promotion of the quality of life for people who are already ill.
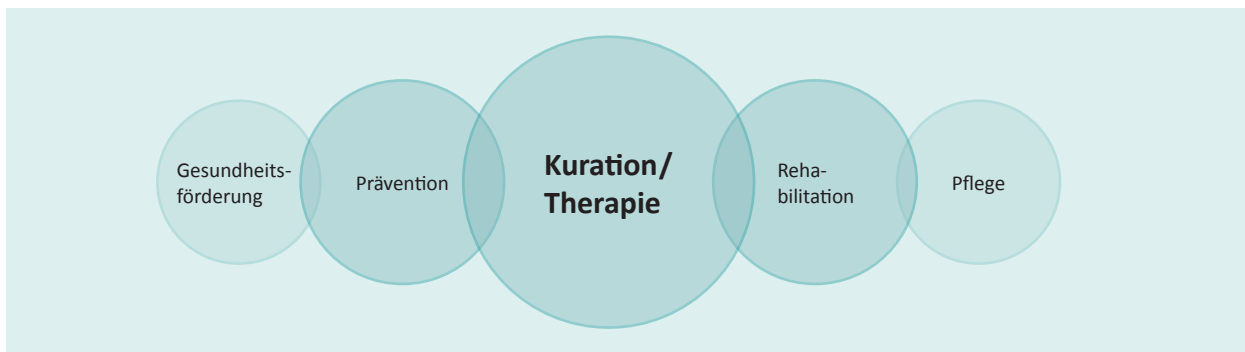
Hurrelmann, K., Klotz, Th., Haisch, J. (2010): Einführung in die Krankheitsprävention und Gesundheitsförderung. In:
Hurrelmann, K. et al. (Hrsg): Lehrbuch Prävention und Gesundheitsförderung. 3. Auflage, Verlag Hans Huber, Bern, S. 19

A modern, integrated view of (occupational) health promotion and prevention can lead these areas to appear as an interdisciplinary issue. Although curative treatment and therapy continues to constitute the central segment in health care, these are linked to disease prevention and health promotion. At the same time, this is also the case in the areas of rehabilitation and care. The end product is a closely-knit system which describes (operational) health promotion and prevention as factors which cannot be detached from other components.
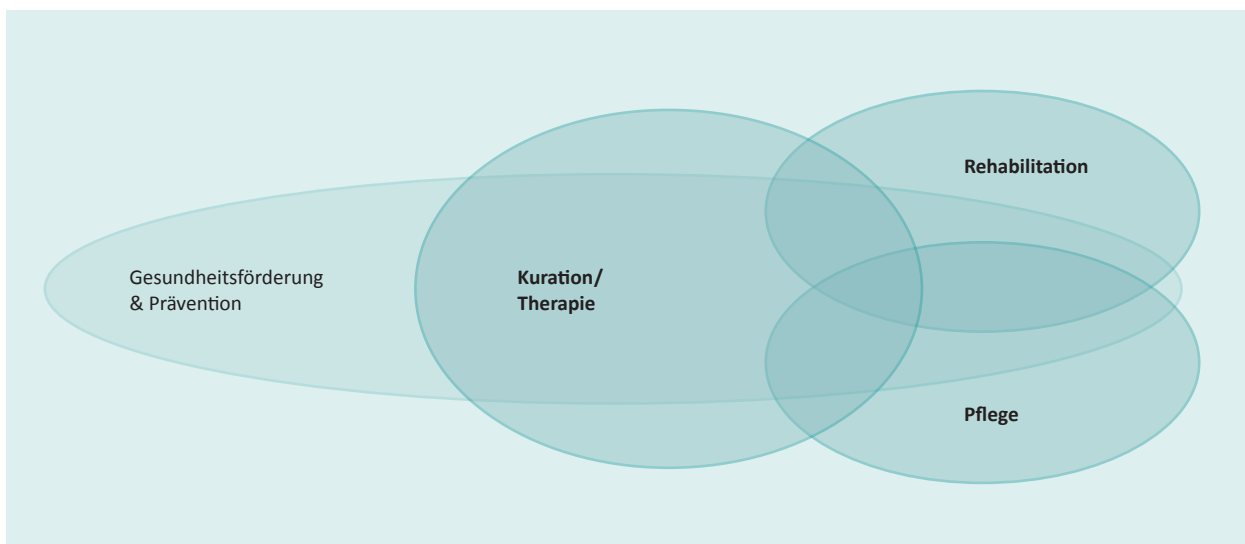
Hurrelmann, K., Klotz, Th., Haisch, J. (2010): Einführung in die Krankheitsprävention und Gesundheitsförderung.
In: Hurrelmann, K. et al. (Hrsg): Lehrbuch Prävention und Gesundheitsförderung. 3. Auflage, Verlag Hans Huber, Bern, S. 19

9.2. Risks

Threats to WHP are possible if a positioning of WHP is not established as a tool and starting point for the promotion of mental health in the sense of an integrative model. This would be associated with a gradual loss of importance of WHP and would stand in the way of further development of WHP.

10. Recommendations for improving the support of employees with mental health problems

Anchor the status, importance and possibilities of WHP as widely as possible and make others aware of it. WHP should be understood as an interdisciplinary issue which means using health-promoting potential in secondary and tertiary prevention.

CROATIA

Joint Action on Mental Health and Well-being:
Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

- Elizabeta Radonic, MD, PhD

National Report: SWOT-analysis Croatia

1.1. Background information

Croatia is situated on the crossroads between Central and South-Eastern Europe. According to the 2011 census it has 4,284,889 inhabitants. Its surface area is 87,661 km², of which 56,594 km² is land area with a population density of 75.7 inhabitants per km². This density varies greatly among different counties. There are 21 counties, 127 towns/cities and 429 municipalities. The capital is Zagreb, with 790,017 inhabitants. The average age of the population is 37.5 (men) and 41 (women), and life expectancy at birth is 71.1 (men) and 78.1 (women). Natural increase is negative, – 2.2 per 1000 inhabitants. By ethnicity, 90.42 % population are Croats and by religion, 86.28 % population are Catholics.

In 2011, GDP per capita was 10,205, economical activity rate 45.7 and unemployment rate 13.5 (13.2 for women and 13.7 for men), the highest rate being in the age group of 15 – 24 (36.1). On March 31th 2011, 426,688 persons were employed by legal entities in state ownership and 639,145 by entities in private ownership; the leading category in state ownership being "Public administration and defence, compulsory social security" (106,352) and in private ownership "Wholesale and retail trade, repair of motor vehicles and motorcycles" (161,324). 46 % of employed persons were women.

Among persons in employment, the rate of persons with university or college education was 13.9 and 7.9 respectively (16.4 and 9.6 for women). The rate of persons with uncompleted elementary school or basic 8-year school was 2.7 and 14.1 respectively (3.2 and 16.0 for women). Among the unemployed, the rate of persons with university or college education was 8.1 and 5.6 respectively (10.0 and 6.9 for women). The rate of persons with uncompleted elementary school or basic 8-year school was 2.6 and 17.0 respectively (no data and 18.5 for women). The unemployment rate is rising and preliminary data for 2013 are 20.4 (average value for January – July).

1.2. Basic structure of health, employment and social security sectors

Government bodies responsible for these sectors are:

- Ministry of Health
- Ministry of Labour and Pension System
- Ministry of Social Policy and Youth

Representatives of the social security systems are:

- Croatian Institute for Public Health
- Croatian Institute for Health Protection and Safety at Work
- Croatian Health Insurance Fund
- Croatian Institute for Pension Insurance

The national insurance-based health system offers universal coverage to all citizens and is provided by the Croatian Health Insurance Fund (CHIF). Health care contributions in Croatia are mandatory for all employed citizens, i.e. their employers. The dependents obtain their health care coverage through contributions paid by working members of their families. Mental health is fully integrated and there is no separate budget allocation for mental health, except for drug addictions. Citizens who belong to a particularly vulnerable category are exempt from paying health care contributions (e.g. retired people and persons with low income). Citizens are generally required to participate in healthcare services, with the exemption of some population categories (e.g., children under the age of 18) or diseases (e.g., emergency cases, malignant diseases, chronic mental illnesses). Supplementary insurance covering services or medications that are not on the mandatory list is becoming increasingly popular.

Health care services, including both general and mental health, are provided at primary, secondary and tertiary level. Primary level services (including, among others, GPs, occupational medicine specialists, psychiatrists and other mental health professionals) are offered in health centers distributed all over the country (but less accessible in low density inhabited areas like islands) and county public health institutes. Health care services on the secondary and tertiary level are mainly rendered in hospitals. Hospitals can be classified as clinical, general and special hospitals. Most promotion and prevention activities are carried out by national/county institutes for public health or the Institute for Health Protection and Safety at Work.

The pension system in Croatia is a mixed public/private system based on three pillars. The first pillar is mandatory, financed by contributions and state budget revenues. It is the responsibility of the Croatian Institute for Pension Insurance, and all employees are obliged to pay 15 % of their total monthly income into the fund. The second pillar is mandatory for persons who were under the age of 40 in 2002 and an additional 5 % of their total monthly income is directed to the second pillar funds (private pension funds). The third pillar is voluntary pension insurance based on individual capitalized savings. The contributions are paid into private capital funds.

Benefits in cash are distributed through various systems; some examples are basic support allowance or child allowance through social policy system, sick leave benefits by employers or the National Health Insurance Fund (depending on the duration of sick leave), maternity leave benefits by the National Health Insurance Fund, unemployment benefit through the Croatian Employment Service. The social policy sector is in charge of social support to people with disabilities, including mental health disabilities (in cash or kind). Representatives of the social partners, academic institutions and professional associations are many, and in this joint action the following contribute:

- Croatian Employers' Association
- Union of Autonomous Trade Unions of Croatia
- School of Medicine – CIBR
- College of Applied Sciences in Safety
- Croatian Association for Occupational Medicine
- Croatian Psychological Association

1.3. Mental Health Legislation and Policy

Components of the promotion of mental health and prevention of mental disorders are integrated in national legislation and various policies. The new Health Care Act was enacted in 2008 and last revised in 2012. The rights of people with mental disorders are additionally protected by the Law on the Protection of Persons with Mental Disorders that was enacted in 1997 and last revised in 2002. The new Law on Social Care was enacted in 2012. The law covers a range of services important for mental health prevention such as psychosocial counselling, early childhood intervention and social inclusion. Community services and civil society participation are promoted by the Law.

The most recent mental health policy is the National Mental Health Strategy 2011−2016. Objectives of the Strategy are: promotion of mental health for all; addressing mental health disorders through preventive activities; promotion of early intervention and treatment of mental disorders; improving the quality of life of persons with mental health disorders or disability through social inclusion, protection of their rights and dignity; development of the information system, research and knowledge in the field of mental health. There are six priority areas: promotion of mental health in the general population; promotion of mental health in age-specific and vulnerable populations; promotion of mental health at workplace; addressing mental ill-health through prevention, treatment and rehabilitation; community mental health care; cross-sectoral collaboration, information and knowledge exchange, research.

The Strategic Plan of the Development of Public Health for 2013−2015 includes prevention of mental health disorders with focus on strengthening early recognition of mental health problems, particularly in high risk populations; implementation of anti-stress and social skills improvement programmes, particularly at the workplace; and screening programmes for mental health problems (particularly for depression and anxiety) in primary health care.

Many other policies have also been developed which include elements relevant for mental health promotion and prevention of mental illness at the workplace: Strategy of Development of Croatia "Croatia in 21st century"; National Sustainable Development Strategy accepted in 2009; National Gender Equality Policy 2011−2015; National Strategy on Equal Opportunities for Persons with Disabilities 2007−2015; Joint Memorandum on Social Inclusion; National Strategy on Combating Narcotic Drugs Abuse 2006−2012; National Strategy on Prevention of Alcohol and Drug Abuse and Related Disturbances, 2011−2016. The implementation of policy measures, though, is impeded in areas where it is grossly dependent on financial resources.

1.4. Mental health status[iv]

According to the Croatian Health Service Yearbook, in 2011 mental health morbidity accounted for 5.8 % (7.3 % in the age group 20−64) of all diseases and conditions diagnosed by GPs. Fifty percent of all mental health diagnoses in primary health care are for common mental health problems – neuroses, mood disorders, stress induced disorders and somatoform disorders. Mental health disorders ranked seventh and accounted for 7.1 % of all hospitalizations in 2011, but in active working age (20−59) it ranked second and accounted for 12.9 % of all hospitalizations; mental disorders due to use

of alcohol being a leading group of diagnoses, followed by schizophrenia, depressive disorders and reactions to severe stress (PTSP included). Cases treated for drug misuse in medical institutions in 2011 (age group 15−64) were 257.0 per 100,000 (207.6/100,000 for opiates). Data from the Disabilities Registry show that 26 % of all disability causes or co-morbid diagnoses are mental disorders and mental retardation.

The suicide rates in the past 15 years have been oscillating, with a declining trend (15.9 per 100,000 in 2011 according to the Croatian Committed Suicides Registry). The same is true for the active working population (12.9/100,000 in the 20−49 age group and 21.5/100,000 in the 50−64 age group in 2011).

2. National stakeholders list

The following actors have accepted to contribute to the Working Package 6:

Ministry of Health
Danica Kramaric, MD, Head, Division for Health Care Promotion and Protection
Dunja Skoko Poljak, MD, Head, Service for Public Health Care
Valerija Stamenic, MD, Head, Department for Programs and Projects
Martina Car, Head, Service for Accession and Structural Funds

Ministry of Labour and Pension System
Zdenko Muratti, Head, Service for Safety at Work
Lidija Hrastic Novak, MD, Advisor to the Minister

Ministry of Social Policy and Youth
Alma Bernat, Head, Service for Care for People with Mental Disabilities

Croatian Institute for Public Health
Vlasta Deckovic Vukres, MD, PhD, Head, Department for Primary Health Care
Maja Silobrcic Radic, MD, Head, Department for Mental Disorders

Croatian Institute for Health Protection and Safety at Work
Bojana Knezevic, Head, Department for Education
Mirjana Pticar, Head, Department for Expertise, Inspection and Forensics

Croatian Health Insurance Fund
Veronika Lausin, Assistant Director for Health Protection at Work

Croatian Institute for Pension Insurance
Jadranka Perasic, Deputy Director
Ksenija Milic Strkalj, Department for International Treaties Implementation

Croatian Employers' Association
Admira Ribicic, Adviser for Legal Affairs

Union of Autonomous Trade Unions of Croatia
Gordana Palajsa, Executive Secretary for Work and Social Legislation

School of Medicine – CIBR
Elizabeta Radonic, MD, PhD, Joint Action coordinator for mental health expert issues

College of Applied Sciences in Safety
Svjetlana Sokcevic, PhD, Professor

Croatian Association for Occupational Medicine
Azra Hursidic Radulovic, MD, President

Croatian Psychological Association
Josip Lopizic, President

3. SWOT Analysis – clustering

3.1. Promotion and protection of health at workplaces

3.1.1 Strengths

Cluster Legal framework

- the existing legal framework is of good quality (particularly the Workplace Health Protection Act) and is being further improved (proposition in public debate) in accordance to EU legislation (in particular concerning stress prevention, mobbing and violence at the workplace, employers' obligations concerning psychosocial risks).

sectors: employers, unions, labour (gov.), academic

- policies and strategies that protect mental health at work (public health, mental health protection)

sectors: health (gov.), social (gov.), public health, occupational medicine

- ratification of Convention of rights of persons with disabilities

sector: social (gov.)

Cluster Professional expertise

- tradition and experience in health protection at the workplace

sector: labour (gov.)

- well-educated experts

sector: social (gov.)

- mental health is included in the curriculum for occupational medicine specialists

sectors: health (gov.), public health

- obligatory education of both employers and employees on stress management

sector: employers

Cluster Implementation and practice

- mental health is part of primary health care system

sectors: health (gov.), occupational medicine

- occupational medicine is part of primary health care system

sectors: health (gov.), occupational medicine

- institutions that contribute to promotion and prevention in the field of mental health

sectors: health (gov.), public health

- obligatory regular check-ups for all workers at occupational medicine specialists, additional check-ups for workers who get ill frequently

sectors: health (gov.), public health

- activities offered by mental health professionals in bigger companies (mainly psychologists in human resources departments)

sectors: health (gov.), public health, health insurance

Cluster Awareness (sub-cluster implementation and practice)

- awareness of the importance of promotion and protection of mental health at the workplace among professionals

sector: health insurance

- awareness of the importance of promotion and protection of mental health at the workplace (public and media)

sector: social (gov.)

3.1.2 Weaknesses

Cluster Legal framework

- preventive measures and procedures are not precisely defined

sectors: employers, academic

- legal framework of poor quality

sector: pension insurance

Cluster Professional expertise

- programmes for continuous education in this area are not adequate (except for mental health professionals)

sector: employers

Cluster Implementation and practice

- occupational health experts are not sufficiently present at workplace itself

sector: employers

- legislative measures are frequently not implemented

sectors: employers, unions, labour (gov.), occupational medicine

- authorities are not efficient in implementing legislative measures

sector: academic

- lack of proper (evidence-based) evaluation procedures

sectors: health (gov.), public health

- sectors develop parallel systems of implementation, thus creating confusion

sector: labour (gov.)

- focus is on separate factors instead of a more general/systematic solution

sectors: labour (gov.), health insurance

- system does not efficiently oblige employers to take care of their employee's mental health – health consequences are often "for free" to employers (e.g there is no bonus/malus motivation, there are no consequences for external expert companies that make inadequate workplace risk assessments and preventive measures recommendations)

sector: academic

- community mental health care is insufficiently developed

sector: health (gov.)

- local authorities support a huge quantity of small projects that are not well coordinated, whereas bigger projects are insufficiently supported

sector: social (gov.)

Cluster Economy/Finances (sub-cluster implementation and practice)

- implementation of policy and strategy measures is inadequate when grossly dependent on financial resources

sectors: health (gov.), public health

- economic crisis causing great existential problems

sectors: social (gov.), unions

- employers' profit is an imperative

sector: unions

- insufficient financial resources allocated for this purpose

sector: unions

- unemployment/unsecure jobs or weak opportunities to find a new one as a source of stress and possible manipulations by employers

sector: state occupational health

Cluster Awareness (sub-cluster implementation and practice)

- insufficient awareness of social partners about the problem, its nature, implications and effects on the world of employment

sector: academic

- weak interest and resources for mental health promotion in smaller and medium enterprises

sector: health (gov.)

- stigmatization of mental health issues by colleagues and employers

sectors: health (gov.), public health, health insurance

- mental health issues seen as weakness in competitive work environments

sectors: health (gov.), public health

- employers and employees in many cases have unsatisfactory/hostile relationships

sector: unions

3.1.3 Opportunities

Cluster Professional expertise

- presence of various profiles of mental health experts at workplace

sector: occupational medicine

Cluster Implementation and practice

- exchange of experience and good practice examples with other MS in the Joint Action

sector: health (gov.)

- dissemination of good practice examples supported by hard economic data among relevant stakeholders, employers and employees

sector: health (gov.), employers

- evidence-based evaluation procedures implemented, with focus on fast feedback to employers and employees

sector: health (gov.)

- implementing only evaluated (that include proper outcome indicators) practices

sectors: labour (gov.), state occupational health

- making approaches and tasks simple to accomplish

sector: labour (gov.)

- improving intersectoral cooperation and exchange of experience

sectors: labour (gov.), occupational medicine

- improving coordination, synchronization and synergy in promotion and prevention programmes

sector: social (gov.)

- introducing transparent mechanisms for prevention of, and action against, mobbing

sector: social (gov.)

- reintroducing social work in employment and education sector

sector: social (gov.)

- provide supervision in all service providing sectors (health, social care, education)

sector: social (gov.)

- at workplace, promoting stimulation rather than penalization

sector: pension insurance

- obligatory education at workplace, not to be financed additionally but by allocation of resources already provided by employers for health care protection

sectors: employers, pension insurance

- educating employees on prevention of stress and depression

sectors: unions, pension insurance

- development of a national service/programmes that could support smaller and medium enterprises who lack experts in the field of mental health promotion and protection and human resources development

sector: health (gov.)

- promotion and prevention should be implemented from early age to prevent problems in adult or old age

sectors: pension insurance, labour (gov.)

Cluster Economy/Finances (sub-cluster implementation and practice)

- bonuses for employee-friendly employers

sector: unions

- to make better use of EU funding in this area

sector: labour (gov.)

Cluster Awareness (sub-cluster implementation and practice)

- promotion of social responsibility in the world of business

sector: employers

- developing better employers-employees relationship

sector: unions

- raising general awareness of the importance of promotion and protection

sector: health insurance

- reducing stigma connected to mental health issues

sectors: health (gov.), social (gov.), public health

3.1.4 Threats

Cluster Legal framework

- tight deadlines for reforms lower the quality of work

sector: labour (gov.)

Cluster Implementation and practice

- complexity of the issue

sector: social (gov.)

- support is often only formal

sector: occupational medicine

- insufficient support and resources for more profound work on these issues

sector: social (gov.)

- complex bureaucracy

sector: labour (gov.)

- lack of mutual understanding among various stakeholders

sector: social (gov.)

- measures recommended, but not obligatory

sector: unions

- lack of support/cooperation by employers and employees

sector: pension insurance

- insufficient education of employers and employees

sector: employers

- stressful new technologies (overload with information etc.)

sector: state occupational health

Cluster Economy/Finances (sub-cluster implementation and practice)

- global economic crisis

sector: health (gov.)

- lack of financial resources

sectors: health (gov.), public health, employers, unions, occupational medicine

- weak national economy

sectors: health (gov.), labour (gov.), pension insurance

Cluster Awareness (sub-cluster implementation and practice)

- low interest in target groups

sector: health (gov.)

- low level of intersectoral cooperation

sector: health (gov.)

- stigma and isolation of people with mental health problems

sector: health insurance

3.1.5 Three most important recommendations for improving the protection and promotion of health in workplaces, particularly in relation to mental demands

- to increase the presence of mental health professionals at the workplace itself

sectors: unions, pension insurance

- to stimulate and support employers' creativity at the workplace

sector: state occupational health

- wherever possible, to adjust requirements of a specific job to individual characteristics of a worker

sector: state occupational health

- to stimulate the organisation of work into 8-hour working days in order to support family life and leisure activities, rather than to stimulate and praise additional working hours

sector: state occupational health

- to educate employers, employees and unemployed on mental health issues

sectors: labour (gov.), health insurance, employers, occupational medicine

- to perform comprehensive, non-superficial analysis of needs as well as support and resources for mental health protection

sector: social (gov.)

- to promote and implement only those good practice examples that have been evaluated based on outcome indicators and are efficient in both health and financial sense

sector: health (gov.)

- to develop employment programmes for social inclusion of people with various kinds of disabilities

sector: pension insurance

- to improve employers-employees communication

sector: pension insurance

- to raise the level of coordination and responsibility

sectors: health (gov.), labour (gov.), employers

- to offer early support and individual approach

sector: health insurance

- personality development

sector: labour (gov.)

3.2 Support for employees affected by mental health problems

3.2.1 Strengths

Cluster Legal framework

- strategies and legislation protecting rights of people with mental health problems

sectors: health (gov.), labour (gov.), unions, occupational medicine

Cluster Professional expertise

- available health care professionals and services

sector: health (gov.)

Cluster Implementation and practice

- measures of re-socialization are being developed

sector: occupational medicine

Cluster Awareness (sub-cluster implementation and practice)

- attention paid to the problem lately

sector: labour (gov.)

3.2.2 Weaknesses

Cluster Professional expertise

- uneducated management

sector: social (gov.)

Cluster Implementation and practice

- jobs/working conditions are inadequate for people affected by mental health problems, which is further worsened by high general unemployment rate

sectors: labour (gov.), unions, pension insurance, state occupational health

- problems are recognized too late

sector: state occupational health

- insufficient coordination with other sectors

sector: health (gov.)

- employees left on their own, often excluded from working process, penalized because of their problems

sector: pension insurance

- mental health problems often misused as excuse for absenteeism or to solve social/existential issues

sector: academic

- lack of support/cooperation by employers and employees

sector: pension insurance

Cluster Economy/Finances (sub-cluster implementation and practice)

- weak national economy

sector: occupational medicine

- insufficient financial resources for supportive measures

sector: pension insurance

Cluster Awareness (sub-cluster implementation and practice)

- social exclusion and disrespect

sectors: labour (gov.), health insurance

- insufficient awareness of the importance of this issue

sector: occupational medicine

- low level of knowledge about mental health problems among employers and employees

sector: state occupational health

- stigma

sectors: social (gov.), occupational medicine

3.2.3 Opportunities

Cluster Implementation and practice

- to better coordinate the social security and employment sector i.e. to establish a formal system (define procedures, providers...) that would support employees affected by mental health problems and provide conditions for them to stay employed

sectors: labour (gov.), employers, occupational medicine

- to develop procedures for better individual support in keeping jobs

sector: health insurance

- part time jobs

sector: unions

- active vacations, physical exercise

sector: state occupational health

- to support direct contact of mental health professionals and employers of persons with mental health problems

sector: state occupational health

- implementing only evaluated (outcome indicators) practices

sector: labour (gov.)

Cluster Economy/Finances (sub-cluster implementation and practice)

- make better use of EU funding in this area

sector: labour (gov.)

Cluster Awareness (sub-cluster implementation and practice)

- to better inform employees about the risk and how to maintain and protect mental health

sector: state occupational health

- education (mental health literacy) from early age (families and schools) to improve awareness and understanding

sector: health insurance

3.2.4 Threats

Cluster Implementation and practice

- low intersectoral coordination

sector: labour (gov.)

- support only formal

sector: occupational medicine

Cluster Economy/Finances (sub-cluster implementation and practice)

- insufficient financial resources

sectors: health (gov), labour (gov.), pension insurance, employers, occupational medicine

Cluster Awareness (sub-cluster implementation and practice)

- discrimination on many levels

sector: health insurance

3.2.5 Recommendations for improving support for employees affected by mental health problems

- to educate both employers and employees on mental health issues and possibilities for people affected by mental health problems to stay employed

sectors: employers, unions

- more flexibility – to make it possible for people affected by mental health problems to combine work and sick-leave in order to support treatment and return to the world of employment

sectors: labour (gov.), unions

- raising flexibility of working conditions respecting both employers' and employees' needs

sector: pension insurance

- organizing jobs/working conditions for people affected by mental health problems so that the tasks are more easily achieved (positive reinforcement is therapeutical)

sector: health insurance

- taking care of employees' attitude (questionnaires etc.)

sector: state occupational health

- to establish intervention teams as support

sector: health (gov.)

- to focus on solutions rather than on problems

sector: health insurance

- increase support to keep people with mental health problems employed

sector: pension insurance

- combating stigma

sectors: health insurance, public health, occupational medicine

- raising awareness and health literacy

sectors: labour (gov.), public health, pension insurance, occupational medicine

3.3 Summary

There is a consensus for almost all aspects of the relevant fields of action, as well as recommendations, according to actors involved. The only differing point of view was the legal framework for promotion and protection of health at workplaces where a representative from pension insurance finds it of poor quality whereas representatives of employers, unions, labour (governmental), and the academic sector find it to be of good quality.

The most important assessed strengths, weaknesses, threats and opportunities, as well as recommendations are as follows:

Promotion and protection of health at workplaces

Strengths:

- existing legal framework, policies and strategies
- activities offered by mental health professionals in bigger companies
- educated experts
- mental health and occupational medicine parts of primary health care system
- obligatory regular check-ups for all workers at occupational medicine specialists, additional check-ups for workers who get ill frequently

Weaknesses:

- legal, strategy or policy measures are frequently not implemented (particularly when grossly dependent on financial resources)
- preventive measures are not precisely defined
- lack of proper (evidence based) evaluation procedures

- parallel systems of implementation creating confusion
- mental health problems are stigmatizing and seen as weakness in competitive work environments

Opportunities:

- disseminating and implementing only practices that were evaluated based on outcome indicators (in respect of both health benefits and financial benefits for employers, employees and society), with focus on simplicity of tasks and approaches
- improving coordination, synchronization and synergy in promotion and prevention programmes
- promotion and prevention implemented from early age to prevent problems in adult or old age
- obligatory education at workplace for both employers and employees
- reducing stigma connected to mental health issues

Threats:

- lack of financial resources
- complexity of the issue
- complex bureaucracy
- lack of mutual understanding among various stakeholders (sectors)
- lack of interest and education in target groups

Recommendations:

- to educate employers, employees and unemployed on mental health issues
- to increase the presence of mental health professionals at workplace itself
- to raise the level of coordination and responsibility

Support for employees affected by mental health problems

Strengths:

- strategies and legislation protecting rights of people with mental health problems
- available health care professionals and services
- measures of re-socialization are being developed
- attention paid to the problem lately

Weaknesses:

- jobs/working conditions are inadequate for people affected by mental health problems, which is further worsened by high general unemployment rate
- low level of knowledge about mental health problems among employers and employees
- problems are recognized too late, employees often penalized because of their problems
- mental health problems often misused by employees to solve non-health related issues
- social exclusion, disrespect, stigma

Opportunities:

- to better coordinate the social security and employment sector i.e. to establish a formal system (define procedures, providers...) that would support employees affected by mental health problems and provide better conditions for them to stay employed

- to support direct contact of mental health professionals and employers of persons with mental health problems

- implementing only evaluated (based on outcome indicators) practices

- make better use of EU funding in this area

- education (mental health literacy) from early age (families and schools) to improve awareness and understanding

Threats:

- insufficient financial resources

- low intersectoral coordination

- support only formal

- discrimination on many levels

Recommendations:

- raising flexibility of working conditions respecting both employers' and employees' needs

- combating stigma

- raising awareness and health literacy

FINLAND

Joint Action on Mental Health and Well-being: Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

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National Report:
SWOT-analysis Finland

Mental health and work disability

On the basis of a population-based study, 6 % of the employed working age population suffered from a depressive disor-
der, 5 % from an alcohol-use disorder, and 4 % of an anxiety disorder in Finland (Honkonen et al. 2007). Mental disorders
are a common cause of work disability. In 2012, 32 % of new disability pensions were granted on the basis of mental
disorders. Together with musculoskeletal disorders (32 %), these account for the main disease groups behind new cases
of chronic work disability. Because mental disorders often begin at an early age and become chronic, they account for
almost half (46 %) of the ongoing disability pensions (Finnish Centre for Pensions and the Social Insurance Institution of
Finland 2013). In addition, 24 % of compensated sickness absence days were granted on the basis of mental disorders in
2012 (Social Insurance Institution of Finland 2013).

Occupational safety and health legislation

Occupational health care act

http://www.finlex.fi/en/laki/kaannokset/2001/en20011383) states that the employer has a duty to arrange occupational
health care for all wage earners. Occupational health care includes assessment of 1) health and safety at work (e.g. work
load) 2) health risks of work, and health and working capacity of the employees. The working capacity of the employee
has to be evaluated after 90-day period of sick leave and the possibilities of the employee to continue working have
to be evaluated. In connection with preventive actions, the employer may also provide outpatient services at GP level
(=medical care contract). One half of the justified and reasonable costs (60 % of preventive actions) are reimbursed from
sickness insurance funds. Entrepreneurs and self-employed may organize OHS for themselves, and they also are eligible
for compensation (Räsänen 2006).

In addition to the occupational health care act, the action of OHS is directed by guidelines (Good practices for Occupa-
tional Health Care: Depression, Good practices for Occupational Health care: Return to work.)

The responsibilities of the employer are also defined in the Occupational Safety and Health act
(http://www.finlex.fi/en/laki/kaannokset/2002/en20020738), which states that the employer has a duty to exercise
care for employees' safety and health at work. The employer has to have an action plan work place's safety and health.
Employer has to identify and recognize health and safety risks of work, work environment, and working conditions. In de-
signing and planning work, physical and mental capacities shall be taken into account in order to reduce hazards of risks
from the workload factors to the safety and health of employees. If the employee is told or finds out that an employee
has adverse job strain, he/she is obliged to assess the situation and start actions to remove or reduce health risks.

The following text is from "Health care in Finland: Brochures of the Ministry of Social Affairs and Health 2eng, 2013" The
full brochure can be accessed at http://www.stm.fi/c/document_library/get_file?folderId=6511570&name=DLFE-26813.pdf

Organisation of occupational health care

Employers can provide the occupational health services internally or outsource them to a health centre, a private medical
centre or other service provider. Local authorities are responsible for providing occupational health care services to any
employers in the municipality who wish to buy them. Entrepreneurs and self-employed people can sign up for occu-
pational health care services if they wish. Approximately 90 % of wage- and salary-earners have access to occupational
health care. Occupational health care addresses issues relating to the workplace, the working environment, and the work
community and individual employees. Cooperation between employers and employees is an important aspect of occu-
pational health care. The primary aim of occupational health care is to maintain and improve work ability. Almost 90 % of
clients who have access to occupational health care services have a medical care contract.

Municipal provision of social welfare and health care services

Local authorities are responsible for organising the provision of social welfare and health care services. The local authori-
ties can organise the provision of services independently or form joint municipal authorities with each other. In addition,
local authorities can outsource the provision of services to other local authorities, a non-governmental organisation or a
private service provider.The basic social welfare, public health and specialised medical care services that must be avail-
able in every municipality are defined by law. Local authorities can decide the scale, scope and model of municipal ser-
vice provision within the limits of legislation. This is why the services available can vary from one municipality to another.
Operations and services are mostly funded by municipal tax revenue. The state supports municipal service provision by
means of central government transfers to local government.

Specialised medical care by hospital districts and catchment areas

Municipalities form hospital districts that are responsible for the provision of specialised medical care. Hospital districts plan and develop the provision of specialised medical care to ensure that primary health care and specialised medical care form an effective whole. Mainland Finland has 20 hospital districts. Each hospital district belongs to one of the five university hospital catchment areas. These coordinate the provision of specialised medical care, information systems, medical rehabilitation and procurement.

Private health care services complement public health care service provision. Private service providers, i.e. enterprises, non-governmental organisations and foundations, can sell their services to local authorities, joint municipal authorities or directly to clients .Enterprises and non-governmental organisations have begun to provide more and more of Finland's health care services in the 21st century. Private-sector service providers account for just over a quarter of all social welfare and health care services. Non-governmental social welfare and health care organisations provide services both for a charge and free of charge. Non-governmental organisations receive a considerable proportion of their funding from public funds and from Finland's Slot Machine Association.
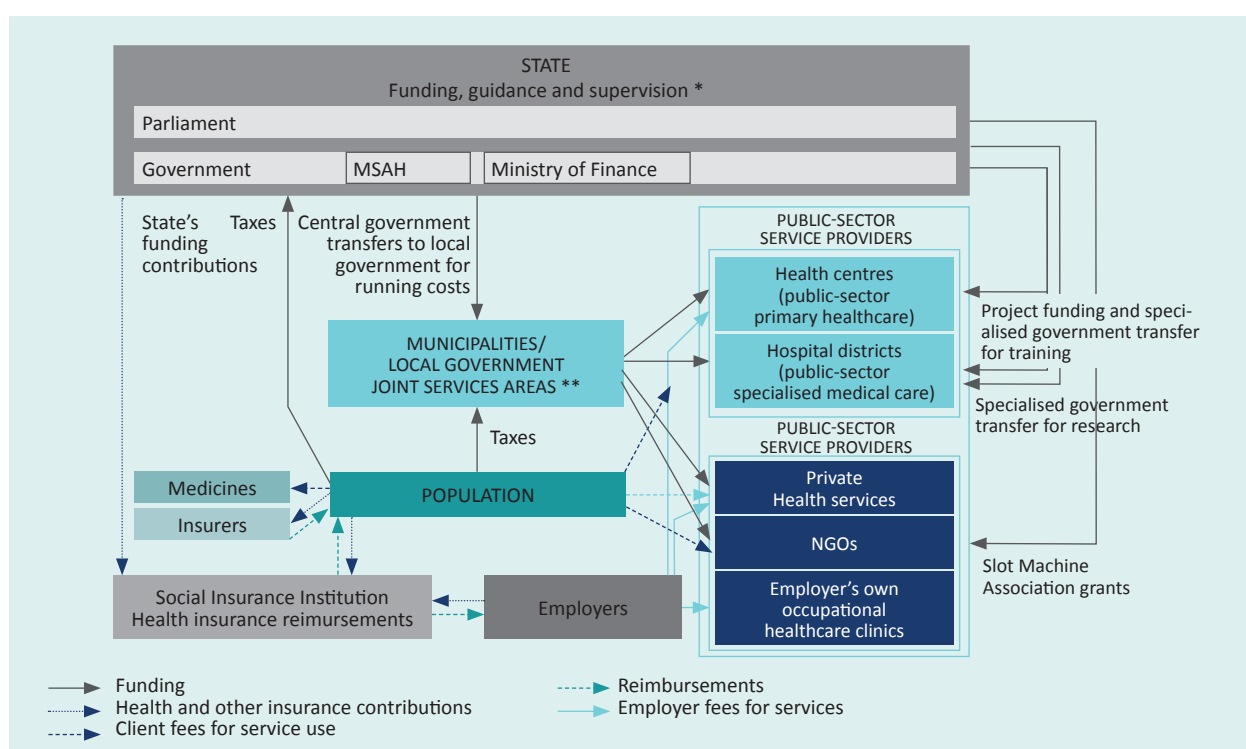
* The Regional State Administrative Agencies National Supervisory Authority for Welfare and Health (Valvira) and The Finnish Medicines Agency (Fimea) supervise healthcare. The following expert institutes are in charge of information guidance: the National Institute for Health and Welfare (THL), the Finnish Institute of Occupational Health (TTL) and STUK – Radiation and Nuclear Safety Authority, Finland.
** Municipalities are responsible for organising the health services required by the population. Primary healthcare should be arranged in municipalities, or local government joint services areas, with at least around 20,000 inhabitants. In fulfilling its responsibility for organising specialised medical care, each municipality, must belong to a hospital district
Figure 1. Organisation, funding, provision and supervision of health care services
Figure: Ministry of Social Affairs and Health: *http://www.stm.fi/c/document_library/get_file?folderId=6511570&name=DLFE-26813.pdf*

Health insurance, medical care insurance and earned income insurance

Statutory health insurance which covers the entire population is divided into medical care insurance and earned income insurance. The Social Insurance Institution of Finland coordinates health insurance, which is part of social security.

Rehabilitation

Medical rehabilitation is aimed at restoring and maintaining physical functional capacity. Health centres and hospitals provide medical rehabilitation as part of medical care. In addition to social welfare and health care service providers, rehabilitation is also available from organisations such as the Social Insurance Institution of Finland, authorised pension providers and employment and education administration. Social Insurance Institution of Finland (Kela) also compensates rehabilitation and guarantees income during rehabilitation (Law on Social Insurance Instutution's Rehabilitation Benefit and Rehabilitation Grant Benefit). Kela compensates rehabilitation psychotherapy for 16−67 year olds if a disorder diagnosed by psychiatrist threatens work ability.

Mental health services

Municipal health services are aimed at improving citizen's mental health and at reducing risks to mental health. These services include guidance and advice, psychosocial support for individuals and communities and mental health services. Mental health services include examinations, treatment and rehabilitation for mental health disorders. Services are available from health centres or, in case of specialized medical care, psychiatric clinics and psychiatric hospitals. Outpatient services are prioritized. Social welfare authorities provide housing services, home help services and rehabilitative work activities. (End of text from "Health care in Finland: Brochures of the Ministry of Social Affairs and Health 2eng, 2013".)

In case the employer provides outpatient services as a part of occupational health care (has a medical care contract), it is possible to receive the services of occupational health nurses, occupational doctors and occupational psychologists also related to mental health symptoms. The (consulting) services of a psychiatrist may also be available. The scale of the services may vary between employers.

Mental health at work: National development projects

Several development projects have been implemented to promote mental health at work, such as Masto-project (2008–2011): a national project by ministry of Social Affairs and Health to promote practices increasing well-being at work and to enhance depression prevention. Two networks have been established to support well-being in the workplace: Management Development Network (to create criteria for good leadership) and Well-being at Work Network (to provide a forum for workplace representatives and experts who are interested in well-being at work). Työelämä 2020 (Working life 2020) is a new large network project focused on working life strategy, led by the Ministry of Employment and the Economy which includes a wide range of actors (Ministry of Social Affairs and Health, Ministry of Education and Culture, social partners, and several expert institutes) to promote quality of working life.

Social welfare and health care in Finland are currently under re-organisation. In the new proposed model, the arrangement and the provision of services will be separated. The responsibility for organizing the services will rest with five social welfare and health care regions. The joint municipal authority in the social welfare and health care region will be responsible for ensuring that the residents in the region and others entitled to use the services receive the services their need. (Ministry of Social Affairs and Health, *http://www.stm.fi/en/ministry/strategies/service_structures)*

Joint Action Work Package 6: Promotion of Mental Health at Work: the SWOT-process in Finland

The Joint action on Mental Health and Well-being WP6: Promotion of Mental health at work in Finland was implemented by the Finnish Institute of Occupational Health authorized by the Ministry of Social Affairs and Health. The stakeholders were identified and contacted in cooperation with the Well-being at Work Network and the WHO Collaboration Centre for Mental Health. In the case that the stakeholder did not have a representative in the network, the senior doctor or well-being at work expert of the organisation was contacted and invited to participate in the workshop or in the interview.

The national swot-analysis was carried out in two workshops, on 23rd (5 participants, pilot-workshop) and 24th April 2013 (24 participants) and complemented with group and individual interviews during the autumn of 2013.
The participants were requested to fill in two different swot-analyses (strengths, weaknesses, opportunities and threats):

- Topic 1: Psychological/Mental well-being and management of work-related strain

- Topic 2: Supporting employees with mental disorders

The results were collected into a table which served as the basis for the summary presented in this report.
The participants were divided in eight stakeholder groups and represented the following organisations:

1. Ministry of Social Affairs and Health
   Department for Occupational Safety and Health

2. Ministry of Employment and the Economy
   Employment and Entrepreneurship Department

3. Employer organisations

   – Ministry of Finance, Office for the Government as Employer

   – Evangelical Lutheran Church of Finland, Church as Employer

   – Confederation of Finnish Industries (EK)

   – Local Government employers (KT)

4. Employee organisations

  – Confederation of Unions for Professional and Managerial Staff in Finland (Akava)

  – Affiliated Unions (SAK)

  – Finnish Confederation of Professionals (STTK)

5. Well-being at Work Network: regional coordinators, OHS experts

  – Satakunnan työterveyspalvelut (Satakunta OHS)

  – Työplus (Työplus OHS)

  – Finnish Institute of Occupation Health

  – Pohjois-Karjalan kansanterveystyön keskusliitto (Central Association for National Health Work in North Karelia)

6. Well-being at Work Network: regional coordinators, well-being at work experts

  – City of Rovaniemi

  – LocalTapiola Group

  – Local Government Pensions Group (Keva)

  – The Centre for Occupation Safety

  – Esedu

  – State Treasury

7. WHO Collaborating Centre for Mental Health Promotion: Collaboration group and the Finnish Association for Mental Health

  – Collaboration group members:

  – National Institute for Health and Wellfare

  – Finnish Institute of Occupational Health

8. Social Insurance Institution of Finland (Kela) Health Department

Summary of main findings

The issues (topics) are presented in the order of importance, i.e. according to the amount of stakeholder groups who mentioned the topic.

Topic 1:
Psychological / Mental well-being and management of work-related strain

STRENGTHS	EXAMPLE
Occupational Health service (OHS) systems	OHS are based on the law. Therefore issues related to mental well-being at work are constantly followed up, and services constantly developed.
Legislation	The legislation related to work includes issues such as occupational health and safety and occupational health services.
Awareness of the issue	General awareness is high; both scientific and practical information is available.
Existing processes	Processes such as risk assessment. Experts are available to support the existing processes.
Open discussion culture	The discussion culture inside the organisation and in general has improved, there is better know-how on how to address the issue at the workplace level.
Active stakeholders	An active group of different stakeholders keeps the issue on the agenda at ministries, in associations, at workplaces, etc.

■ All/almost all of the stakeholder groups	■ About half of the stakeholders groups	■ One or two stakeholders groups

WEAKNESSES	EXAMPLE
Level of knowledge in the assessment of mental strain at work	The level of knowledge of superiors and industrial safety personnel in the assessment of mental strain at work; what are the causes behind it? Those feeling strain are not always able to discuss the issue with their superior.
General demands of work life	The level of demands has risen: "Nothing is enough any more"; the pace of changes is fast.
Organisation of work tasks, work processes	Work tasks can be too obscure, they are sometimes unclear, which makes it difficult to set limits to amounts of work; new ways of working need new rules.
Solving problems	The problems are outsourced to OHS, more cooperation between the employer and OHS is needed.
Processes as part of everyday practices	The existing processes and tools have not become a part of everyday practices at workplaces.
Negative talk	There is more negative than positive talk about work and its problems. There is a need to change the focus to solutions and opportunities.
Use of OHS	The use of OHS for prevention is too limited, the focus is more on the treatment of illnesses.
Use of employees who are partially fit for work	Employees who are partially fit for work are not used enough, more advantage should be taken of existing possibilities.
Medicalization	The medicalization of problems.
Attitudes	The attitudes towards those with mental health problems are too negative; people are seen as either sick or healthy.
Changes in work life	Rapid changes in work life and organisational restructuring; attention must be paid to change management processes.
Work community skills	Weakness in work community skills, e.g. how to act in cooperation, how to give feedback to each other

OPPORTUNITIES	EXAMPLE
Job crafting, organisation of work	New ways to modify job contents; more flexibility in working life; leadership has improved; individual differences are taken into account.
Use of existing models, processes	Information, practices, and tools are available which should be utilized more efficiently, for example, the early support model
Networking	Cooperation between different stakeholders is increasing; cooperation is seen as a typical way in which to work.
Legislation	Psychosocial risks and issues related to them are taken into account in legislation. 60 % compensation from Kela (the Social Insurance Institution of Finland) when organisation's OHS meets the preventive action criteria
Preparation, anticipation	More attention is paid to anticipating work-related strain; more systematic planning of processes targeting recovery; more communication targeted at small- and medium-sized organisations.
Teaching of work life skills	Work life skills are introduced at different educational levels; Actions against inappropriate behaviour are part of school life, young people get used to procedures, how to handle situations, control them, etc.
Mental strain is seen as a serious matter at the political level	Mental strain is seen as a serious matter at the political level; development of practices is considered important
Appreciation of ageing employees	The skills and knowledge of ageing employees are seen as valuable assets.
Resources at work	Each workplace also has resources to help maintain well-being; attention should also be paid to these.

All/almost all of the stakeholder groups   About half of the stakeholders groups   One or two stakeholders groups

THREATS	EXAMPLE
Global economic situation, diminishing resources	Uncertainty of economic situation; increasing job insecurity; less personnel – less resources.
Increasing workload	The demands of work life have increased, there is more strain. The working population risks becoming exhausted, which will lead to early retirement. The goal of longer working careers may not be reached.
Problems are individualized	Medicalization of problems, individual-level focus of actions. Problems in the wider workplace setting are not taken care of.
Resources of superiors	Superiors have too many subordinates to take care of; they do not have enough time or resources.
New risks	Globalization, teleworking etc. make work more boundless, it is difficult to control work, or notice the warning signs of mental strain on time. Workplace violence from frustrated customers.
Difficulties in replacement	Difficulties in replacement/re-employment; finding appropriate work tasks; employability of employees.
Long-term development	There is a lack of long-term development of working conditions, things are resolved on the basis of short-term solutions.

Topic 2: Supporting employees with mental disorders

STRENGTHS	EXAMPLE
Existing support processes at the workplace	Models for early support , job modification and flexibility. The pension system encourages employers to "keep their employees". Good rehabilitation options are available to those who have a permanent job. cooperation between social security and vocational institutes is being developed.
Occupational Health service (OHS) systems	OHS systems work well for those who have a permanent job.
Attitudes	Attitudes towards mental health and illness have developed in a better direction.
Rehabilitation, social insurance system	Vocational rehabilitation, job modifications. Rehabilitation has been developed to make it possible to combine studies and rehabilitation. Cooperation between rehabilitation and the workplace is being developed.
Existing health services	The services exist. The processes may be developed.
Awareness of the issue	General awareness is high; both scientific and practical information is available.
New legislation	30-60-90 days rule, partial sickness allowance, access to rehabilitative psychotherapy, therapy has been made easier, criteria for vocation rehabilitation has been partly moderated.
Research information and experts	There are experts and research information.

WEAKNESSES	EXAMPLE
Cooperation between OHS and workplace Cooperation between OHS and special health care	Cooperation and flow of information between workplace, OHS and special treatment does not always work well. There are regional differences in availability of treatment. Long waiting lists for psychological and psychiatric treatment.
Negative attitudes towards mental illness	Mental health issues are feared, there is a lack of willingness to hire or keep employees who suffer from mental disorders.
Lack of awareness and know-how	Lack of ability to identify and deal with mental health problems at the workplace.
Work opportunities for employees with mental health problems	Availability of appropriate jobs. Legislation does not make it easy to employ new part-time workers. Return to work should be dealt with earlier in vocational rehabilitation.
Unemployment, non-typical employment	Non-typical employment has become more common. Employees in permanent jobs are supported at the workplace and entitled to OSH services, while those in non-typical employment and unemployed receive weaker support and services.
Not taking the whole working career into consideration	Narrow view of work ability, seeing only the current situation and current workplace. Instead, the whole working career should be taken into consideration.

OPPORTUNITIES	EXAMPLE
Fitting different support mechanisms together throughout the working career	Arrangement of mental care, rehabilitation and financial support systems as a whole in order to enable the continuation of the working career.
Support for return to work	Using remaining work ability, making work modifications accordingly.
Making use of existing knowledge	Spreading information on mental health issues to workplaces.
Work supports good mental health	Positive experiences and the social community at work improve self-esteem and functioning.
30-60-90 day rule	Checkpoints for work ability and necessary action determined in the legislation.
Models for early support of work ability	Early supervisor-employee dialogue and workplace interventions help. Stigma is reduced when the workplace learns that these issues can be handled successfully.
Supervisor support	Good supervisor support promotes continuing at work.
Reform of health and social services	Creating structures for good care and practices.

THREATS	EXAMPLE
Social exclusion	Mental health problems and unemployment lead to social exclusion, especially among young people. Polarization of society into those who stay employed and those who do not.
Problems in treatment	Treatment starts too late. Prevention does not occur in real life. The role of different services is not clear.
Stigma	Mental health issues are feared and workplaces do not want to deal with the issue. Employees fear negative attitudes if they speak about their mental health.
Integration employees with partial work ability	The idea that all employees must be able to give 110 % all the time. Tight economic situation reduces willingness to hire or keep employees who cannot make a full effort.
Workload and mental health	The association between heavy workload and mental health problems is not acknowledged
Medicalization	The medicalization of problems and seeing them as problems arising from individual employees.
"Experience society"	People only look for new experiences and do not commit to anything long term.

- All/almost all of the stakeholder groups
- About half of the stakeholders groups
- One or two stakeholders groups

The most relevant needs for improvement

Topic 1: Psychological/Mental well-being and management of work-related strain
Three main development actions recommended:

1. Knowledge must be increased and resource-based practices should receive more support. Concrete interventions to develop processes and interaction.

2. Cooperation should be increased.

3. The approach to developing working conditions should be prevention-orientated. Systematic assessment of strain.

Topic 2: Supporting employees with mental disorders
Three main development actions recommended:

1. Early support models and models for return to work should be used in all workplaces.

2. Jobs should be modified; new type of jobs in which tasks can be adjusted to individual needs.

3. Attitudes towards mental health issues must change. Awareness should continuously be raised at workplaces. The mental health problems should be demystified.

Key observations

Most of the stakeholders agreed that general awareness regarding mental health is quite high; both scientific and practical information is available and the knowledge-base is strong. It was seen that during recent years, the attitudes towards mental health problems have developed in a good direction, but mental health disorders still need to be demystified. Some of the stakeholders emphasized that employees with mental health problems still face problems in finding or keeping work, both because of a lack of appropriate jobs and employers lack of willingness, or because of complicated processes to employ them.

The existing legislation related to work, such as occupational health and safety and occupational health care were widely mentioned as strengths. As OHS services are based on the law, issues related to mental well-being at work are constantly followed up, and services are developed. The development of legislation was seen as an opportunity. The most recent improvements in legislation mentioned were: 60 % compensation from the Social Insurance Institution of Finland when organisations' OHS meet the preventive action criteria, the "30-60-90 days rule", which defines checkpoints for work ability during sickness allowance, partial sickness allowance, and easier processes to obtain compensation for rehabilitative psychotherapy. In addition, existing processes, such as risk assessment, early support and job modification were mentioned as strengths. However, it was mentioned that the processes and tools have not become part of everyday practices in all workplaces. Deficiencies were particularly detected in identifying and assessing mental strain at work. It was seen that tools for the assessment of strain exist, but there is a great deal of variation in applying them to everyday life at workplaces. There still is a need for training and dissemination of processes and tools. Development needs were detected in the organisation of work tasks and work processes. New ways of working need new rules.

Mental health care in OHS was in most cases seen to work well. However, most of the stakeholders detected problems in cooperation and flow of information in two areas: 1) between OHS and the workplace and 2) between OHS and special health care. In addition, some of the stakeholders saw that problems are sometimes outsourced to OHS and solving them at the workplace is neglected. Some of the stakeholders emphasized that employees with permanent jobs receive the most support, treatment and rehabilitation, while those with non-typical job contracts receive less support, and services for the unemployed (who are not entitled to OHS) are at a weaker level. Cooperation between different stakeholders was seen to be increasing; networking is seen as a typical way in which to work.

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FRANCE

Joint Action on Mental Health and Well-being:
Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report: SWOT-analysis France

Introduction

The SWOT survey was carried out in France between April and December 2013, in the form of a questionnaire sent by post or email to all the persons identified as possibly being interested in the survey. The replies were then collected either by telephone or by email, or during face-to-face meetings. They were then analysed and grouped together in the same table used for the SWOT survey, which can be found in the first part of this report.

The list of people who took part in the survey is as follows:

- Philippe Bielec, Occupational Risks Department (DRP), French national health insurance fund for employees (CNAMTS);
- Boris Vieillard, special adviser, Labour Department, Ministry of Labour and Social Affairs;
- Geneviève Castaing, head of the "Psychiatry and mental health" bureau, Health Department, Ministry of Social Affairs and Health;
- Patricia Vernay, Head of the healthcare and risk prevention policy section of the national social security fund for self-employed workers ("RSI");
- Isabelle Burens, special adviser in the occupational health department, ANACT;
- Loïc Lerouge, research assistant at CNRS;
- Nathalie Bué, French employers' association MEDEF;
- Jean-François Naton, confederal adviser, CGT trade union;
- Henri Forest, confederal secretary, CFDT trade union;
- Patrick Néron, confederal adviser on working conditions, CFTC trade union;
- Nicolas Froment, OPPBTP (occupational risk prevention organisation for the building and civil engineering industries);
- Michel Niezborala, doctor and labour inspector, DIRECCTE Midi-Pyrénées;
- Michaël Prieux, labour inspector;
- Dr Muriel Raoult-Monestel, doctor and regional labour inspector, Lower Normandy (Basse Normandie).

In France, psychosocial risk prevention (PSR) forms part of the general obligation of occupational risk prevention. The Act of 31 December 1991 obliges the employer to take the necessary measures to ensure the safety and protect the health of workers. In France, according to established legal precedents, this is an obligation of care for the safety of others and not merely a "best endeavour" obligation.

The decree of 5 November 2001 made it compulsory to enter the inventory of risks at the level of each work unit in a single document. The "loi de modernisation sociale" of 17 January 2002 supplemented the existing legislation regarding two points which help to clarify the obligation of taking into account psychosocial risks in the same way as all other occupational risks:

- On the one hand, it specifies the employer's responsibility for protection of the physical and mental health of the company's employees (Article L. 4121-1 5 of the labour code ("Code du Travail");
- At the same time, it introduces in the labour code new articles which define and sanction mobbing (articles L. 1152-1 to L. 1152-6 CT).

In addition, several national interprofessional agreements give definitions and indications for preventing psychosocial risks. These agreements were signed by all the employers' and trade union organisations:

- The national interprofessional agreement on work-related stress of 2 July 2008.

This text transposed the European framework agreement on work-related stress signed on 8 October 2004. It was made compulsory for enterprises by an official ministerial decision of 23 April 2009. Its purpose was to "Increase the awareness and understanding of work-related stress, by employers, workers and their representatives; draw their attention to signs that could point to work-related stress problems, and this as soon as possible; provide employers and workers with a framework to allow them to detect, prevent, avoid and cope with work-related stress problems".

- The national interprofessional agreement on harassment and violence at work dated 26 March 2010.

On 26 March 2010 the French social partners signed this agreement, which was extended by an official decision on 31 July 2010. Its provisions have therefore been rendered compulsory for all employers and all employees within its scope of application as of that date. It invites enterprises to state clearly that harassment and violence in the workplace are not tolerated, and to provide for appropriate management and prevention measures. This national agreement is the transposition of the European framework agreement signed in 2007. It supplements the national interprofessional agreement on work-related stress.

- The national interprofessional agreement for a policy of improving the quality of life at work and job equality dated 19 June 2013.

This agreement aims to promote equal access to quality of life at work and job equality for all employees. The aim is to increase awareness and understanding of the issues at stake by all the stakeholders (including employers, employees and their representatives). The issues are expressed in terms of improving the quality of employment, well-being at work and the performance of the organisation. This agreement creates no extra obligations for enterprises.

- The agreement for psychosocial risk prevention in the civil service dated 22 October 2013.

This agreement provides for the establishment of a national action plan on psychosocial risk prevention in the civil service, which will involve the preparation, by each public employer, of a PSR assessment and prevention plan.

Summary of replies to the questionnaire on mental health at work in France

PSYCHOSOCIAL RISK PREVENTION (PSR)			
What, in your opinion, are the strengths and weaknesses of the policies/measures currently adopted to prevent psychosocial risks in France?		For the future, what, in your opinion, are the main opportunities and threats for psychosocial risk prevention in France?	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS/RISKS
Government incentives for enterprises to take into account PSR prevention: • Agreements on stress, violence and harassment; • Health at Work Plan 2010–2014; • Labour Code and allowance for mobbing.	Lack of legal obligation: • Incentives to sign agreements but no obligation; • Role of the CHSCT (committee for health, safety and working conditions) should be increased; • No precise legal framework on PSR and no legal definition of PSR.	Involvement of enterprises: • Human resources more closely involved; • Step up the initial efforts in terms of training, initial or continuous, for managers and supervisory staff; • Increase the number of OH&S personnel in enterprises.	Economic crisis: impact on the funding of risk prevention: • Funding of risk prevention and research structures endangered; • Reduction in risk prevention resources and workplace inspections.
Growing general awareness of the subject by all the stakeholders (government, social partners, OH&S personnel, enterprises, doctors, public opinion, etc.) and progress by social partners on this subject at the national inter-professional level.	No comprehensive approach to these risks: • PSR prevention has been separated from the rest of risk prevention; • Lack of an economic approach: no cost-benefit analysis of risk prevention.	Change attitudes: • Talking about competitiveness leads to questioning about work capacity and efficiency and the need for well-being at work; • Show enterprises the benefits of risk prevention, especially in terms of costs; • Emphasize the principle of "adapting work to humans"; • Work on the impact of changes and work organisation. • Strong social request, • Induced costs of PSR will keep institutional and social partners concerned, • The evolution of psychiatrists who care more about the impact of work in the psychic equilibrium.	Economic crisis: risk that PSR could be pushed into the background.

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STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Available tools and methods, existence of national indicators, improvement of statistics.	Lack of tools and communication with enterprises: • Definition of these risks still vague; • Insufficiency of risk assessment and the single document to prevent PSR; • Lack of instruction of the personnel in charge of this subject (especially in communication with enterprises); • Lack of research on the impact of risk prevention on performance, and of cost/benefit analyses of risk prevention; • Available risk prevention methods not enough adapted to corporate needs, • Bonds and methodologies which take insufficient account of factors such as industry, size or economic context of businesses.	Creation of new tools and networks: • PSR measurement tool (INSEE-DARES survey) available to better understand risk factors; • Will for improved coordination between the various networks of stakeholders that could act in the field; • Risk prevention and health personnel better prepared for handling PSR; • Improvement in the monitoring of statistics concerning PSR (notably due to the expert committee ("collège d'expertise") and the classification of risk factors).	Economic crisis, increased risks: • Tougher working conditions which could lead to an increase in PSR; • Job insecurity which could force employees to accept working conditions that they would not have accepted previously, • Risk of manipulation of the subject by some employers and some employees.
Training and awareness raising for all the stakeholders.	Difficulties for SMEs and self-employed workers: • Inappropriate tools; • Little visibility regarding the situation of SMEs and self-employed workers, and relatively ignored in health policies.	Develop whistleblowing systems for employees.	Individualization of work relationships and risk of focusing on individual measures, low trade union membership in enterprises. (hence the challenge for trade unions to mobilize on these issues and to restore contact with employees to be truly their spokesman).

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STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Importance of the role of the CHSCT (committee for health, safety and working conditions) and its possibility to get some expertise	Lack of results and non-priority subject in enterprises: • Few branch agreements but some agreements in large firms; • Action plans applied in enterprises are corrective rather than preventive; • Little data concerning work-related suicides; • Few tangible results of preventive measures; • Risks that are complex, hence difficult to prevent; • Not a priority for enterprises (employment issues are of highest priority); • Lack of awareness, especially on corporate boards; • Industrial doctor not always available on these issues, • A network of OSH prevention liberals whose skill level is very variable.	Revitalization and evolution of labour relations around working conditions.	• The CEOs of very small enterprises are called on only to protect the health of any employees they have. Their own risks and their own health are not considered. There is a high risk of overlooking a large fringe of the labour force. • A narrow focus on managers and not enough on management policies.
Existence of various networks and working groups on the subject, multidisciplinary work of all actors.	No recognition of work-related mental health disorders as occupational diseases.	Possibility for the judge of overriding the employer's management authority to invalidate a work organisation that could adversely affect workers' health	Focusing on PSR at the expense of other risks (physical risks in particular).
Reform of the occupational health services ("IPRP").	Difficulties with retention in or return to the workplace of people who are ill (tertiary prevention).	Re-examine the media handling of work-related suicides to avoid making them seem commonplace.	Risk of discouragement of enterprises and need to include PSR prevention in all activities (education, sport, culture).
Link between RPS issues, painful working conditions, gender equality, quality of working life and risk prevention.	Feebleness of penalties due to companies' failure to comply with obligations. Legal summons seldom used and not very dissuasive penalties.	Specific PSR survey established by the DARES from 2015, alternating with working conditions surveys.	Lack of rules ensuring the independence of corporate OH&S personnel relative to their employer.
	Lack of training of managers and executives; OSH is not included in the curricula of the "grandes écoles".		Lack of a precise definition and effective checking of the competencies of OH&S personnel.
	Major gap between theoretical discourse and the real way to tackle the problem.		Decline in the number of industrial doctors.
			Instrumentalization of work-related suicide as a means of protest.

PROMOTION OF MENTAL HEALTH AT WORK

What, in your opinion, are the strengths and weaknesses of the measures currently adopted to promote mental health at work (well-being/quality of life at work) in France?		For the future, what, in your opinion, are the main opportunities and threats for the promotion of mental health at work (well-being/quality of life at work) in France?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Growing awareness of social partners and enterprises thanks to the national negotiations on the quality of life at work. Territorial and institutional networks and agencies involved in the field of prevention of occupational risks (among others): INRS, ARACT, INVS, INPES, ministries of health and labor, ...	The quality of life at work is still too focused on individual behaviour (healthy lifestyle, behavioural measures).	Decompartmentalize the concept of well-being at work and psychosocial risk prevention (quality of life at work, painful working conditions) and go beyond the corporate framework because well-being at work is not merely the responsibility of the enterprise (notably for the self-employed).	Leaving aside the work organisation and focusing on employees' behaviour (influence in particular of the Canadian "Healthy Enterprise" standard).
A high-quality offer and training tools and the existence of a national reference system to allow for health at work in manager training courses.	Problems of definition and penalties: • Definition of the quality of life at work not yet stabilized; • Amalgam between mobbing and psychosocial risks. • A vague concept, knowledge still insufficient.	Political will to move forward on this subject (at the European and national levels): • Develop policies for return to the workplace; • Include the subject in public debate.	Economic crisis.
Vigour of social dialogue and employees' right of expression.	Lack of action in companies, notably regarding work organisation.	Encouragements for social dialogue and revival of the issue of the employee's right of expression.	Need for social dialogue in the enterprise and consultation with OH&S organisations.
Comprehensive approach to PSR: • Handling of PSR no longer as a risk but at the level of the work organisation itself; • Occupational health issues are now linked to public health issues. • Thinking on the quality of life at work throughout the work career: how to adapt the working life to allow for longer active lives and the breakdown between working and personal life. • The promotion of health at work requires having an overall view of the enterprise and a collective and multifactorial approach, i.e. an approach which encourages listening and dialogue.	Not a priority in enterprises: • Not part of our culture; • Risk prevention remains the priority with regard to promotion; • Not connected to corporate realities. • Not easily applicable to self-employed workers and micro-enterprises, unlike large enterprises.	Develop intersectoral initiatives on the factors determining mental health, involving all the relevant stakeholders.	Risk of job insecurity: • Inequalities between employees (subcontractors, atypical jobs); • Job insecurity.
Recognition of psychosocial disorders: • Mental health disorders related to aggression during work are fairly easily recognized as occupational injuries. • The public prosecutor follows up the labour inspector's warning regarding danger to human life (but still not very frequent).	Lack of evaluation of the effectiveness of actions of quality of working life.	Opportunity for the development of employees' adaptability and resilience.	Lack of obligations for enterprises.
Many tools and surveys exist.		Renewed interest of experts and professionals for this topic (sociologists of work, ergonomists), making sure also to popularize the subject among professionals and citizens.	

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RETENTION IN EMPLOYMENT AND SUPPORT FOR ILL EMPLOYEES

What, in your opinion, are the strengths and weaknesses of the measures currently adopted to support employees affected by mental health problems in France?		What, in your opinion, are the future opportunities and threats regarding support for employees affected by mental health problems in France?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Good case management by health workers (health insurance organisations, occupational risk prevention personnel, industrial doctors and occupational health departments in companies): • Network of occupational health services; • Consultation centers of occupational pathology network; • Quality of the French social system.	No comprehensive action and no link between health and work: • Little coordination between stakeholders (family doctors, industrial doctors, HR, institutions, etc.); • Problem of training of the medical profession (health–work link not established); • Suspension of the employment contract during sick leave prevents action taken by the company; • Ill employees receive little support in their initiatives: difficulty of the link between health at work and public health. • Inadequate training of primary care physicians (GPs and specialists) on the effects of work on health.	Raise awareness and encourage cooperation between the various stakeholders.	Individualization of relations in the enterprise and focusing on personal support.

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STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Fairly robust legal system in the obligation placed on companies to support the ill employee and propose redeployment measures.	Small number of centres for consultation on occupational diseases.	Encourage a return to the workplace. New programmes in France to promote early return to work.	Problem of training of employee representatives on these issues.
Existence of measures to support the employee: therapeutic part-time, financing for adaptation of work stations, measures for support and listening to the ill employee.	Complexity of situations and difficulty of finding solutions in enterprises: • Deficient system of retention in employment; • SMEs not greatly concerned; • Difficulty of risk prevention and support for self-employed workers.	Next occupational health plan will include this subject and could be relayed in the regions.	Deintegration and growing number of cases.
Stronger presence of risk monitoring and prevention in the enterprise.	Few checks and penalties for enterprises and difficulty of denouncing inappropriate working conditions (fear of dismissal).	Development of new job positions for intervention in companies in case of disputes.	Taboo associated with psychiatric illness (for employers, managers and work colleagues).
Recognition of mental health disorders following work-related aggression as occupational injuries.	No recognition as an occupational disease, and hence no support (reserved for victims of occupational injuries).	Improve recognition of the work-related origin of psychosocial disorders.	Support reduced to financial compensation only and not real investment on return to work when possible.
An issue which goes beyond PSR and is included in the various action plans and programmes.	Lack of evaluation of the effectiveness of measures to support workers, particularly in terms of improving – or a minimum of not worsening – the proven psychological state.	Deploy the agreements on quality of life at work in enterprises, and return of employees' right of expression.	Lack of occupational doctors.
A comprehensive policy for the integration and continued employment of disabled workers. A policy against discrimination.		Awareness raising of GPs on the importance of working in mental health.	

RECOMMENDATIONS TO IMPROVE MENTAL HEALTH AT WORK

- Deal with mental health more comprehensively
  - Mental health at work cannot be separated from other occupational health issues.
    The promotion of mental health at work should meet the same requirements as the promotion of health in general: all environmental determinants are interdependent.
  - Do not deal with PSR separately from other risks. For example, it is well known that MSD can be both the cause and the consequence of a somatic stress.
  - Mobilize all the stakeholders in order to act on all levels of risk prevention, collective and individual, organisational and personal.
  - The quality of work is an issue that must be handled by all the stakeholders and not merely by the employer.
  - Consider mental health as forming an integral part of the employee's health in general. Have a comprehensive approach: PSR should be dealt with generally in risk prevention at the levels of both the enterprise and the state.
  - Include the work universe and its health workers in thinking on the provision of healthcare services, notably with regard to detection of and support for psychological suffering/mental illness at work.

- Encourage social dialogue and coordination between stakeholders
  - Restore social dialogue to solve problems.
  - Employees' right of expression: introduce democracy into the workplace.
  - Allow employees and their representatives to take part in the governance and design of the work organisation.
  - Increase the use and effectiveness of collective bargaining for the improvement of mental health at work.
  - Oblige enterprises to negotiate and establish measures for preventing psychosocial risks.

- Change the work organisation and human resource management
  - Return to human resource management that is both meaningful and common-sense: the HR methods used in recent years should be reappraised.
  - Make human beings the company's key concern again, with company managers having a real knowledge of the state of health of their employees.
  - Give advice and explanations to those in charge of employees. Restore the human aspect of management (more dialogue, fewer performance indicators).
  - Need to examine the question of work organisation in the enterprise.
  - Develop the role of alert of all internal stakeholders in companies.
  - Establish structures to get involved as early as possible when the warning indicators appear.

- Develop training
  - Training for employers but also for trade unions.
  - Train future managers and administrators regarding occupational health and social dialogue issues.
  - Include OSH in study curricula from early childhood.

- Develop tools and encourage risk prevention
  - Develop studies designed to pinpoint the causal links between psychosocial determinants and psychological suffering/mental illness at work in order to improve their recognition.
  - Need to publish studies which establish a link between risk prevention and performance, costs and benefits of risk prevention in order to convince enterprises.
  - Equip enterprises to better manage change, which is a source of PSR for employees (perform impact studies, develop simulation tools).
  - Identify convincing methods validated at the scientific level for action on psychosocial risks in the work environment.
  - Develop collections of best practices by industry sector and by company size, in order to promote the most realistic and most efficient risk prevention methods, most widely recognized by company managers.
  - Improve the visibility of the link between work and mental illness (studies, recognition of illnesses).
  - Take into account small enterprises and very small enterprises and self-employed workers.
  - Improve warning systems regarding mental health at work in the enterprise.
  - Check for and penalize a lack of risk assessment and OSH measures.
  - Create appropriate tools for SMEs, pleasant and practical to use.
  - Continue efforts to clarify concepts, measure the costs involved, develop appropriate methods of intervention and assess the measures implemented.
  - Making effective, that is to say punishable, the obligations on companies regarding non deteriorating health of the workers employed as a result of organisations.

- Need for thinking at the European level (European Commission, Foundation, Agency) regarding the question.

RECOMMENDATIONS FOR RETENTION IN EMPLOYMENT – PATIENT MONITORING

• Improve case management for ill employees
   – Struggle against disintegration and for retention in employment.
   – Develop the establishment of a plan of return to work coordinated and involving all stakeholders inside the company and outside, including occupational physician.
   – Promote the active role of the employee in the process.
   – Establish a system for the employee to have a unique referent that will follow him durong his leave but also when he comes back to work.
   – Work on the prejudice of discrimination due to mental illnesses in order to eliminate it.
   – Continue developing specific actions and funding to keep disabled people employed, especially when disability is rooted in a mental health problem.

• Improve coordination between actors
   – Improve cooperation between the networks of care, of occupational health and the companies, in order to develop devices for early return to work.
   – Have a mandatory control by occupational doctors before going back to work after a leave of at least 90 days.

• Provide help to the companies
   – Develop a guide for companies.
   – Provide helps and fundings to companies in order to adapt the position or consider training for the return to work as quickly as possible in good conditions.

• Create a table of occupational diseases for psychological injuries.

Qualitative interpretation key learnings on national level

1.Consensus / dissidence concerning the most relevant needs for improvement

One of the greatest difficulties encountered in psychosocial risk prevention in France is managing to motivate and help enterprises establish concrete measures in their premises. The issue of PSR often remains a non-priority subject for them compared with employment or the prevention of other risks. The lack of research demonstrating the benefits of PSR prevention from an economic viewpoint is regrettable, because that could have an incentivizing effect for enterprises once the cost-benefit ratio was demonstrated. Since the legal framework is not very constraining and the sanctions in case of non-application are not very dissuasive, few enterprises have established a real action plan.

It is also very difficult to reach SMEs and self-employed workers. It should also be noted that the existing tools and methods to support enterprises in their initiatives are still insufficiently adapted to their needs and to the specific features of each of them according to their size, sector of activity, the economic situation, etc. PSRs are very often treated distinctly and separately from other risks, and a more comprehensive approach is lacking.

The fact that the recognition of psychological harm related to psychosocial conditions of work is possible only in conditions that are very restrictive and very heterogeneous from one region to another does not help encourage companies to prevent them.

Preventive measures and measures to promote mental health are still highly focused on individual behaviour rather than on a new work organisation. Moreover, company leaders and managers lack training on these subjects and are not assisted much.

Furthermore, the link between work and health is often not established, due to a lack of training of the medical profession and for want of coordination of the various stakeholders.

2.Consensus / dissidence concerning the most efficient / effective practices

Awareness/understanding (stigma)
Increasingly there is a unanimous, across-the-board awareness by all the stakeholders (government, social partners, enterprises, OSH personnel and public opinion) of the importance of mental health at work. As a result of negotiations on the quality of life at work, awareness of mental health at work is more comprehensive and this issue is no longer treated merely as a risk but also at the level of the work organisation itself. Moreover, it is noted that occupational health issues are now linked to public health issues.

Although the definition of psychosocial risks still remains vague, tools and methods are nevertheless available to monitor them, and plans and agreements have been adopted at the national level to encourage enterprises to take into account these risks. The following are mentioned, for example:

- The existence of national indicators

For example, the work performed by the expert committee ("collège d'expertise") on the statistical monitoring of these risks, chaired by Michel Gollac (2011), made it possible to establish an initial overview of psychosocial risks at work in France, and propose national indicators to monitor six types of factors of psychosocial risks at work.

- Signature of national interprofessional agreements on work-related stress, harassment, workplace violence and the quality of life at work

The signature of these agreements shows the vitality of social dialogue in France and the will of the social partners to deal with this subject.
The 2010−2014 Occupational Health Plan of the Ministry of Labour, in which psychosocial risks are a priority.

- Nation-wide surveys

Several coming surveys will include a specific section on psychosocial risks (survey of working conditions, SUMER survey, etc.). The INSEE will also carry out a major survey on psychosocial risks in 2015, which will fit in between the surveys of working conditions carried out every seven years.

- The national network for vigilance and prevention of occupational diseases ("RNV3P")

The national network for vigilance and prevention of occupational diseases ("RNV3P") is an occupational health monitoring and prevention network which covers the 32 occupational disease consultation centres ("CCPPs") in mainland France and a sample of occupational health services associated with the network.

Dissemination of good practices in enterprises
Numerous tools and brochures are available for enterprises, provided in particular by the ANACT and INRS.
However, the benchmark for all the players remains the website created by the Ministry of Labour entitled
www.travailler-mieux.gouv.fr.

This site contains a large quantity of information on psychosocial risks and proposes tools intended in particular for small businesses to help them better understand psychosocial risks. This work is the result of collaboration by a working group set up and coordinated by the Ministry of Labour (Labour Department), involving the main OSH organisations. The "Faire le point" ("Review") tool, developed by the INRS, allows enterprises to try to determine the presence of PSR or not by answering about forty questions. It provides keys for understanding and paths of action for prevention.

Mental health care system
The case management of sick employees by healthcare professionals is good. Employees affected by mental health problems can be identified by the occupational medicine department and then taken charge of by the health insurance organisation.

The establishment of a consultation network for victims of suffering at work in the consultation centres on occupational diseases is also a step forward, although there is not yet a sufficiently large number of these centres.
The network of industrial doctors, occupational risk prevention personnel and inter-company occupational health services can take charge of sick employees.

There are also support measures for sick employees in the form of therapeutic part-time work, financing for the adaptation of work stations, or again measures for support and listening to sick employees.

However, the problem has still not been addressed for self-employed workers, who are hard to identify and include in this system and for whom a mental health problem has a major impact, because their family, their business and potentially their employees may be affected.

Implementation of OSH standards
The legal framework relating to mental health at work in France is rather controversial. Some find that it is not sufficiently precise and constraining for enterprises. Moreover, the sanctions in the event of companies' failure to comply with their obligations are not very dissuasive.

The role of the committee for health, safety and working conditions (CHSCT) in psychosocial risk prevention is therefore emphasized by various players. In companies with more than 50 employees, the employer must present to the CHSCT a

written report reviewing the general situation with regard to health, safety and working conditions, and a programme for prevention of occupational risks and improvement of working conditions. In companies without a CHSCT, the employee representatives duly have all the responsibilities of that Committee.

In the event of a serious risk detected in the company or a major plan to change health and safety conditions or working conditions, the CHSCT can call on an authorized appraiser. The CHSCT can also take legal action when occupational health and safety law is not complied with by the employer.

This power of the CHSCT is appreciated, especially the possibility of calling on an expert appraiser outside the company. However, there are those who request that a reform of the CHSCTs be carried out in order to further reinforce their responsibilities.

Intersectoral cooperation (health and labour)
The existence of networks and good cooperation between the various stakeholders is therefore noted both at the national level (between the Ministry of Labour, the ANACT and INRS, for example) and at the level of territorial networking between the Labour Inspectors, the network of pension and occupational health insurance funds (CARSATs), occupational health services and "Aract" organisations for working conditions.

However, it should be noted that there are no measures concerning mental health at work in the current 2001–2015 mental health plan promoted by the Health Department in the Ministry of Social Affairs and Health. Moreover, for the Ministry of Labour's 2010–2014 Occupational Health Plan, the Ministry of Health was not involved in its preparation or as a partner for the planned initiatives.

In the case management of sick employees, it is also noted that there is very little interaction between the various players: the family doctor, occupational doctor, human resources, OSH personnel, etc.

GERMANY

Joint Action on Mental Health and Well-being: Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report: SWOT-analysis Germany

Introduction

This report is part of the European exchange of ideas on mental health issues in the framework of the European programme Joint Action on Mental Health and Well-being, which began under the leadership of the Portuguese Health Ministry and the University of Lisbon in early 2013. The programme takes previous measures on the European level as its point of departure, including political declarations of the member governments, and seeks to provide a contribution to strengthening the mental health of Europe's population. The German Federal Ministry of Health commissioned the BKK Dachverband (BKK Federal Association of Company Health Insurance Funds) to direct a country consortium on the sphere of activity in the world of work.

Beside Germany, this consortium consists of representatives from the following ten countries: France, the Netherlands, Finland, Austria, Ireland, Croatia, Malta, Hungary, Iceland, and Slovenia (Belgium). The health ministries have delegated the implementation of the planned measures to the relevant national organisations.

The main goal of the Joint Action is to improve the infrastructure for companies and government administrations in the participating countries, in particular to establish improved cooperation between the health care sector and the sector of labour and social policy. In many European countries, access to ambulant psychotherapeutic care is quite limited for those affected; as a rule, the health care sector is limited to curative measures with a minimal engagement in the field of prevention. This often leads to poorly developed structures of cooperation between the sectors of labour and health care.

In particular, mental health at the workplace reveals how important it is to coordinate measures toward health protection, promotion and care on both a company and an inter-company level.

In order to organize the exchange of information in an efficient way, a SWOT analysis was undertaken (strengths, weaknesses, opportunities, and threats) in all participating countries with the participation of key players from the fields of the social partners, government authorities for health, labour, and social policy, the social security system (social insurance programmes, state health agencies, etc.), and company practitioners.

In Germany, around 100 institutions were invited to participate in this process of gathering ideas. The process was supported by the work group Betriebliche Gesundheitsförderung (Workplace Health Promotion) at the Federal Ministry of Labour and Social Affairs. The contributions submitted will be compiled in a "national map of ideas" that reveals both similarities and differences.

Then, in a second step, these national maps of ideas will be integrated into a European map of ideas, from which priority issues can be derived for the exchange of ideas. The European Commission thus hopes to derive recommendations for action on various levels as a foundation for improving practice in the member states.

Key Players in Mental Health at the Workplace in Germany

To ease the understanding of the following results of the SWOT analysis for interested readers from other European countries, the following is a brief summary of the development and orientation of the current structure of key players in Germany.

The Federal Republic of Germany can look back on a long tradition in the fields of occupational safety and humanizing work life. Against the backdrop of broadening perspectives on the aspects of promoting good health, since the mid-1980s, several social insurance providers and social partners have collaborated in the field of workplace health promotion and in the international and national networking of relevant activities, institutions, and key players, for example, the European Network for Workplace Health Promotion (ENWHP) and the Deutsches Netzwerk für Betriebliche Gesundheitsförderung (German Network for Workplace Health Promotion, DNBGF).

Furthermore, in the late 1990s, a stronger commitment and network formation took shape on a political level. For example, in 2002, under Germany's former minister of labour Walter Riester, the network INQA (Initiative Neue Qualität der Arbeit, or New Quality of Work) was founded.

By way of changes in the Occupational Safety Act and in Social Code Book VII, framing conditions for the Gemeinsame Deutsche Arbeitsschutzstrategie (GDA, Joint German Occupational Safety and Health Strategy) were established in

November 2008, thus initiating a paradigm shift in the landscape of occupational safety and health in Germany. As a long-term coordinated effort of the Federal Government, the states, and occupational accident insurance companies for improving health and safety at the workplace, one of the goals of GDA is to manage already existing occupational safety and health measures in a unified and transparent way and to promote their implementation at the workplace over the long term. With the GDA, Germany is also implementing a central requirement of the EU's Community Strategy for Safety and Health at the Workplace from 2007–2012, which stipulates the development of national occupational safety and health strategies in the member states. Today, the term "mental health at the workplace" is used in many discussions and contexts, but does not paint a clear picture of the responsibility and the area of the central players in this field.

German occupational safety and health law defines the protection of the employees suffering from mental strain as the responsibility of each employer, consistent with European occupational safety and health regulations. In addition, the law on labour/management relations regulates company and staff councils' rights of involvement and participation.
On an inter-company level, employers are advised by the statutory accident insurance (part of the German social welfare system) and the labour protection offices, and monitored in terms of the implementation of the legal protection requirements.

Beside labour and health protection, the statutory health insurance providers (another part of the German social insurance system) support corporations in implementing measures for workplace health protection, these also include measures towards workplace health promotion, which also includes health promotion in cases of mental strain. These measures are voluntary for employers; the health insurance providers offer support depending on a catalogue of criteria and in the framework of a limited budget as part of general health care. In the meantime, the statutory accident insurance and the statutory pension insurance also offer advice.

For several years now, every employer has been obliged to offer occupational integration management to all employees who have fallen ill for a longer period of time, including those affected by a mental illness. The central supporting participants in this area include medical officers, rehabilitation agencies (pension, health, unemployment, and accident insurance), integration experts, and integration offices. In addition to the public agencies, a broad market of private service providers has emerged that employers can turn to as well. On the public legal level, three initiatives currently deserve emphasis:

a) Joint goals of health promotion and prevention goals in the world of work of the statutory health insurance with the goal of mental health

b) The Joint German Occupational Safety and Health Strategy (Gemeinsame Deutsche Arbeitsschutzstrategie) with the goal of occupational safety and encouragement in case of psychological stress

c) The Initiative Neue Qualität der Arbeit (Initiative New Quality of Work, INQUA) with the joint programme Psychische Gesundheit in der Arbeitswelt (Mental Health at the Workplace, or psyGA);

One of the INQA funded projects is Psychische Gesundheit in der Arbeitswelt (Mental Health at the Workplace, or psyGA). On the basis of the finding that the deficits in the field of workplace health promotion, in particular in terms of the field of mental health, are not the result of a lack of knowledge but a lack of implementation, the project will use the foundation of a quality concept for mental health in the workplace to bundle know-how and coordinate and implement transfer measures.

According to a decision of the Nationale Arbeitsschutzkonferenz (National Occupational Safety and Health Conference, NAK) from 30 August 2011, the Federal Government, the states, and the accident insurers will orient their prevention activities in the GDA period from 2013 to 2018 primarily towards the implementation of the three joint occupational safety and health goals. They include the target of "protection and improvement of health under work-related psychological stress." The questions of the SWOT analysis are closely related to the GDA target.

The National SWOT Participants

The selection of national players took place on the basis of personal contacts and many years of cooperation in various networks, some of which were already mentioned in the introduction. These include for example:

• The Betriebliche Gesundheitsförderung work group (Workplace Health Promotion) at the Federal Ministry of Labour and Social Affairs (BMAS)

• Coordinating circle of the Deutsches Netzwerk für Betriebliche Gesundheitsförderung (German Network for Workplace Health Promotion, DNBGF)

• Steering Committee "Psyche," Gemeinsame Deutschen Arbeitsschutzstrategie (Joint German Occupational Safety and Health Strategy, GDA)

107 national participants from the following fields were included in the survey: ministries and government organisations, service providers in health care, unions and employer associations, social insurance providers, science and scholarship, and companies.

SOCIAL INSURANCE PROVIDERS

Statutory Health Insurance Providers	**Pension Insurance**	**Accident Insurers**
1. GKV-Spitzenverband	1. DRV	1. DGUV, Munich
2. BKK DV		2. Unfallkassen, Hessen
3. AOK-BV		3. Unfallversicherung, Hamburg
4. vdek		4. BG Nahrungsmittel und Gastgewerbe
5. HKK		5. BG Rohstoffe und Chemie-industrie
6. BAHN-BKK		

SOCIAL PARTNERS

Employer Associations	**Unions**
1. BDA	1. IG-Metall
2. AGV-Versicherungen	2. Verdi

National SWOT Analysis

Health Care Service Providers
1. Aktionsbündnis seelische Gesundheit
2. Research Establishment for Applied System Safety and Health
3. German Association for Psychiatry, Psychotherapy and Psychosomatics
4. Bundespsychotherapeutenkammer
5. RegMed Bonn Rhein Sieg

Science and Scholarship
1. Sozialforschungsstelle Dortmund
2. University of Hanover
3. Bielefeld University
4. Institut für angewandte Arbeitswissenschaft e.V. in Düsseldorf

Ministries and Governmental Organisations
1. BMAS

Companies
1. Siemens
2. Salzgitter
3. Telekom
4. MTU
5. Audi
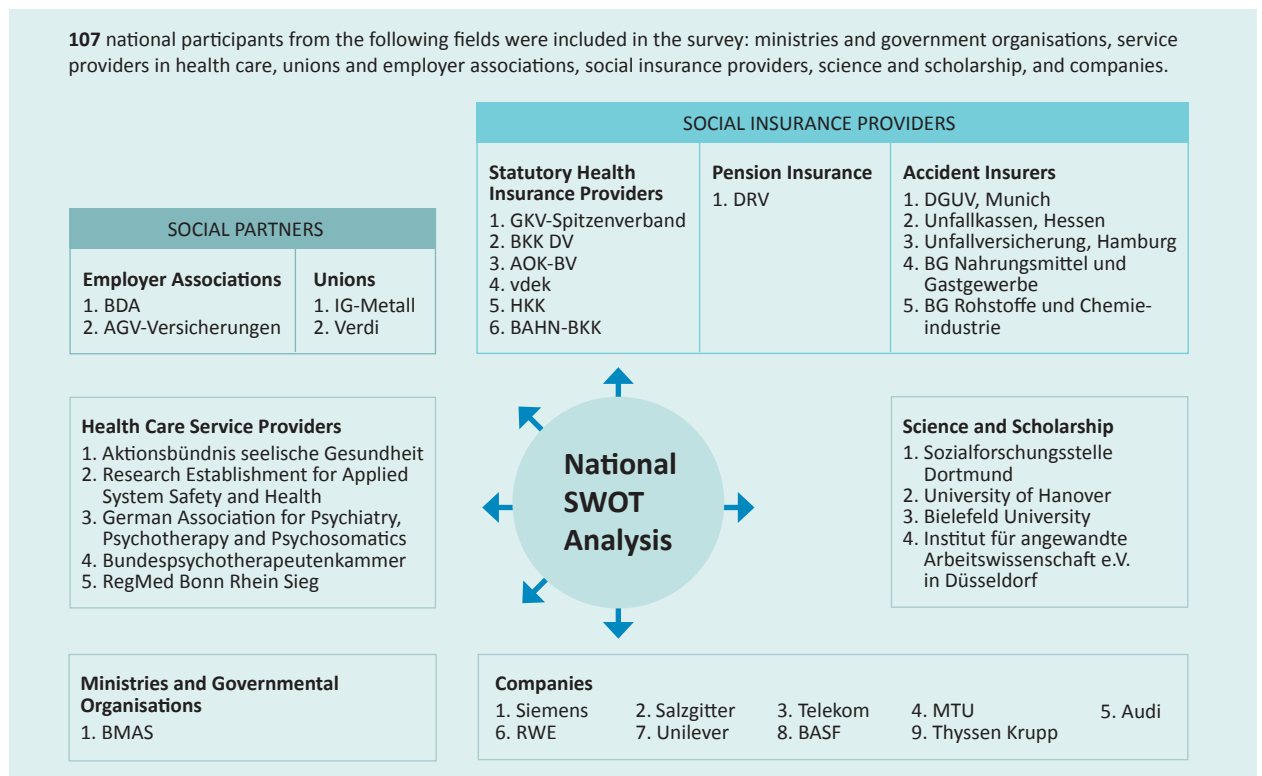6. RWE
7. Unilever
8. BASF
9. Thyssen Krupp

Fig. 1: National SWOT Participants (Source: Gregor Breucker, 22 October 2013)

- The business network Enterprise for Health, led by the Bertelsmann Stiftung and BKK Dachverband (BKK Federal Association of Company Health Insurance Funds)
- Additional experts, particularly in the field of health, occupational safety and health policy, and healthcare provision

The relevant areas and participants in the national SWOT were presented in October 2013 at the meeting of the working group Betriebliche Gesundheitsförderung (Workplace Health Promotion, AK BGF) at the Federal Ministry of Labour and Social Affairs in Berlin.

The following is a comparison of a list of 105 national players invited to participate in the SWOT consultation and the responses received.

AREAS	NUMBER OF REQUESTS	RESPONSES
Ministries, government organisations, and state institutes on work and health protection	17	1
Unions/employer associations (social partners)	8	4
Social insurance providers	26	13
Science, research, and scholarship	5	4
Service providers in the areas of health care, occupational safety and health, workplace health promotion	19	5
Companies	29	9
Other	1	0
Total	105	36

Beside the purely quantitative distribution, there are conspicuous characteristics in terms of the industries selected to take part: the participating companies were mostly DAX listed companies from the realms of steel working, the automobile industry, transportation, energy, consumer goods, communication, and the chemicals industry.

An industry that has become highly qualitatively and quantitatively significant in recent years, not only against the backdrop of demographic developments, the healthcare service and heath industry was not directly represented in their role as employers or by their professional association. Other service providers also only participated in the SWOT indirectly through the accident insurers and the service union ver.di. Some of the statutory health insurance providers that responded were among the first ones who primarily shaped workplace health promotion in Germany. They were key players in the field of national and international network formation. The majority of SWOT participants from the health and accident insurance providers were psychologists.

We only know in several isolated cases how the responses came about and whether or not internal discussions were held. For example, the BKK response was discussed beforehand with around 30 experts who work for the BKK in the field of workplace health promotion.

A company medical officer returned two report parts: one of which was created by the company's division for health and safety. Two employees were named among the responses from the two unions who participated in the SWOT.

The Approach

For the meeting of the work group Health Promotion at the Federal Ministry of Labour and Social Affairs in October 2013, an interim analysis was already presented in table form based on 14 responses about strengths and weaknesses of health protection and promotion at the workplace and support and treatment of employees affected by mental health problems as well. They were to be complemented and modified by comparison with other responses.

To obtain an overview of the total results, the 36 SWOT participants' answers to individual questions were summed up in a table that stretched over almost 75 pages. This also recorded how many entries could be counted per question in which feedback was recorded.

As a whole, the questions in Part 2 (see fig. 2), which deal directly with employees with mental health issues, both in terms of the strengths and weaknesses of current measures and opportunities and threats to future provision, were responded to with less frequency and less detail than the corresponding questions related to the workplace (part 1).

WP 6 SWOT – PART 2			
What are the strenghts and weaknesses of measures currently taken to support employees who are affected by mental health problems? (1)		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems? (2)	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
What would be your three most important recommendations for improving support for employees affected by mental health problems? (3)			
RECOMMENDATIONS			

Fig. 2: SWOT Questions, Part 2 (Source: Gregor Breucker, 22 October 2013)

The extent of the responses varied highly in terms of quantity. The individual responses were generally complex, comprehensive, and sophisticated. For the representation in the appendix, they were not divided into partial aspects: this was done in order to avoid trivialising the content.

This SWOT, by involving all relevant inter-company players in the field of health and labour policy and the reflection of good practice, is intended to offer a foundation for developing a European frame of action for promoting mental health at the workplace.

To obtain a better overview of the response behaviour for the purposes of interpretation, in a second step the responses were systematically arranged according to levels of action, areas, and content aspects. The classification in terms of levels of action was not always clear, or can only be deduced from the overall complex of answers of the respective SWOT participant.

For the following representation of the results and for the appendix, a systematization was chosen that first shows overarching aspects and then specifications in terms of the particular area of action, players, or measures.

The Results in Detail

Part 1:
Health Protection and Promotion at the Workplace under Mental Strain

The most frequently answered question was which strengths and weaknesses mark the current state or current measures for the protection and promotion of health at the workplace under mental strain. Only one response contained no information on strengths; the most comprehensive of the seventeen individual responses came from the business world and contained, among other things, indications on extensive workplace-specific strategies and offers.

In every response, at least two weaknesses were noted. The most extensive lists of weaknesses, with 14 and 17 individual items, came from a health insurance provider and a company.

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An overview of the emphases in terms of content:

STRENGTHS: HEALTH PROTECTION AND PROMOTION OF HEALTH FOR PEOPLE FACING MENTAL STRAIN AT THE WORKPLACE
• Consciousness shift: Lifting the taboo on the subject of mental well-being, increasing acceptance, a broader and partially more nuanced depiction of the subject in the media
• Improved research, increase in knowledge, broader know-how in workplace health promotion, occupation health and safety, and health protection
• A good foundation with workplace health promotion and workplace health management and high competence among long-term actors, for example, among several social insurance providers
• Greater pressure to act resulting from demographic developments and other trends with their impact on the work world (lack of skilled employees, work-life balance)
• Strengthening through legislation and other legal regulations as well as company guidelines
• An increased importance placed on the subject in important policy areas
• Progress in the area of collaboration, networking (for example GDA, psyGA)
• More differentiated range of providers and services
• Increasing sensitivity, qualifications and measures taken (in large companies)
• Programmes, good practice and incentives facilitate spread

Here, as a good foundation for the progress achieved and further activities, particular mention was made of the comprehensive activities of the statutory health insurance providers, the many years of experience in workplace health promotion, and collaboration and networking with other players, as evidenced by the GDA and in the psyGA project.

The consensus achieved, for example, about foundations on the approach and the quality of the relations of collaboration, the programmes elaborated, strategies and measures, formed as central orientation that could be further developed in the companies themselves. However, on a company basis, a comprehensive approach in terms of workplace health promotion/workplace health management including mental health is mainly considered possible in large companies, where it is sometimes also implemented. A number of different examples of good practice and measures were mentioned on an operational level (see appendix).

The broad and positive representation of altered (legal) conditions and labour protection was put into perspective by the description of weaknesses on almost all points. The points of criticism referred to the depth of regulation, reliability, and a lacking (monitoring of) implementation.

Weaknesses also resulted from goal and interest conflicts that take place with increasing workload and lacking leeway for manoeuvre in terms of shaping the workplace on a company level.

Here an overview of the most important weaknesses:

WEAKNESSES: HEALTH PROTECTION AND PROMOTION FOR PEOPLE FACING MENTAL STRAIN AT THE WORKPLACE
• Still too much of a taboo, the stigmatisation of those affected and counterproductive labelling (for example, burnout); low priority placed on the subject at companies
• Legislation and other regulations are too imprecise and are not (sufficiently) implemented, doubt in the practicability of the instruments and approaches, lack of company incentives
• Insufficient security of action in the realm of risk assessment
• Under the label "workplace health promotion", offers are mostly behaviour-based, the shaping of work conditions is generally neglected; implementation problems, particularly in the realm of small to mid-sized companies
• No unified definition, confusion of terms, deficits in research and knowledge among central key players, lacking resources and competence
• Weakness in support from social insurance providers and work and health insurance protection, shortcomings in the cooperation between the social partners, exploitation of the topic
• The range of offerings, instruments, and service provider's leads to confusion, can lessen quality, and prevent action; the quality, practicability, effectivity, and efficiency of the measures are controversial or implausible
• Economic crises, acceleration and increased workloads prevent sustainable and widespread implementation

On the future opportunities and threats, 35 SWOT participants responded for each category. Here there were also 17 individual items mentioned by a responding company.

A high level of agreement was revealed on the estimation that demographic developments will strongly promote the value placed on good work in general, the pressure on companies to act, a lifting of the taboo on the subject, and the acceptance of people with different perfomance profiles. Additional social developments and trends and changing value orientations will increase efforts towards a better balance between requirements and resources.

The opportunities can be summed up as follows:

OPPORTUNITIES: HEALTH PROTECTION AND PROMOTION FOR PEOPLE FACING MENTAL STRAIN AT THE WORKPLACE
• Overall transformation of the world of work, demographic developments, lack of skilled personnel, and change in values among employees support opportunities for change
• Legal frameworks, rules and regulations (when possible Europe-wide) promote an awareness of the subject and its implementation in companies
• On the political level, an increased interest in the issue and its impact on the economy leads to an increase in the significance of (company) prevention
• An openness towards the subject is growing once again and an increasing number of businesses of all sizes are taking on the subject – also as a factor in competition
• The pressure to act in the companies is leading to more activities targeted to specific groups, for example, catered to older employees and woman. The possibilities for a comprehensive implementation of workplace health promotion and workplace health management are increasing
• Collaboration of (non) corporate players is increasing
• Due to their involvement, the acceptance of the social insurance providers is increasing; their competence is increasingly growing, for example, as part of collaborations (GDA), thus contributing to a more objective discussion
• Unions are working increasingly in this area

On a political level, responses indicated a noticeable increase and broadening of interest, as is shown in a shift of perspective in health policy towards more prevention and in altering our systems of incentive. Opportunities for players in the field of labour protection and among the social insurance providers were seen in the increasing acceptance of their expertise and competency as consultants.

Responses indicated that employee representatives and employers support the treatment of the subject and the implementation of measures on a company level. Here, many opportunities for improvement were recognized. Beside sensi-

tization and qualification of company players, respondents found that other external agents would endorse the internal offers and support the measures.

Equally, threats were identified in terms of all mentioned areas of content and action, as shown in the following overview. On an individual level, respondents found these threats in the increasing demands placed in all areas of life that could lead to an increase in disorders and illnesses. The responses criticized the already existing lack of sufficient and adequate care.

With a changed economic situation, the responses indicated that the strategies, programmes, and good results on a company level would probably soon be open for discussion. Threats were also seen as the result of mergers and staff reduction among important external supporters (health insurance providers, professional associations).
Different opinions were expressed on whether additional legal measures are urgently necessary.

THREATS: HEALTH PROTECTION AND PROMOTION FOR PEOPLE FACING MENTAL STRAIN AT THE WORKPLACE
A limitation to the world of work is as misleading as unnuanced discussions; the primacy of the performance society and competition lead on the whole to an increase in constant overtaxing, inappropriate stress at the workplace, and crises in gratification
Due to macroeconomic factors like economic downturns and business pressure, the subject once again threatens to disappear from the political agenda
Disputes over legal regulations and other conflicts between the social partners can prevent the implementation of measures on the company level
Companies pursue short-term economic interests; the consequences are trivialized, problems individualized, the weak are sorted out, responsibility assigned to health experts or an insufficient health care system
Certain management systems, competition within the company, a service orientation, permanent availability, growing demands in terms of mobility, and similar factors contribute to an increase in workload
Conflicts over goals and interests among social insurance providers; staff cutbacks among consulting and monitoring institution; recruiting problems among medical officers
One-sided orientation of measures leads to behavioural changes in the person concerned

In response to the question on the "three most important suggestions toward improving health protection and promotion at the workplace," in 32 responses more than 90 answers were recorded. They dealt primarily with the following:

RECOMMENDATIONS: HEALTH PROTECTION AND PROMOTION FOR PEOPLE FACING MENTAL STRAIN AT THE WORKPLACE
Overarching suggestions
• Make the discussion more objective and professionalized and a clear commitment of the stakeholders
• Clarify terms, transfer knowledge, and close research gaps
• Improve networking and collaboration on the political and institutional level
• Promote a respectful company culture, organisational and employee orientation
• Anchor the subject in company cultures, organisational and staff development processes
• Integration and dissemination through workplace health promotion and workplace health management
Occupational safety and health
• Expand competencies, offering more security
• Develop and present a few coordinated instruments: for small to mid-sized companies as well
• Receive adequate resources and financing, more oversight staff
• More closely monitor the implementation of state regulations
On the enterprise level
• Develop a culture of respect, systematic treatment of the subject for example in workplace health management, use acquired knowledge and know how to develop, implement, and evaluate structural measures
• Avoid aimless activism; keep health protection and promotion in mind in developing the organisation and staff
• Sensitization, qualification, and support of leaders and other internal actors, for example, medical officers, safety experts, addiction and social counsellors, interlining responsible specialist divisions and/or inclusion of external experts
• Keep health protection and promotion in mind when selecting, training, and developing managers
• Involve the worker's council in risk assessment
• Sensitization and strengthening the employees for their own health and the early inclusion in processes
• Keep in mind special circumstances for small companies

Part 2:
Supporting Employees with Mental Health Issues

The questions in part 2 focused on supporting employees with mental health issues. As a whole, there were more responses here on current weaknesses than on strengths. General issues of resources and cooperation between internal and external partners in the framework of health care provision were the subject of sharper focus.

On the question of support for those affected, the group of service providers in health care, in work and health protection, and in workplace health promotion and workplace health management responded in a comprehensive and nuanced fashion in terms of the number of responses, while only a few remarks were made by the group of social partners as a whole.

An overview of the thematic emphasis of the opportunities mentioned:

STRENGTHS: SUPPORT AND TREATMENT OF EMPLOYEES AFFECTED BY MENTAL HEALTH PROBLEMS
High standard for psychotherapy/psychiatric care
With legal provisions such as occupational reintegration
Both in society as a whole and on the company level, an awareness about the issue is growing along with sensitization for those affected and their specific needs
Good supply structures by networking with external providers, support offer and example of good practise can be found primarily in large corporations. Here, various groups, such as managers or security specialists, are qualified to work with those affected
Relevant support offerings with social insurance providers are seen in a positive light (for example, consulting and intervention concepts on experiences of violence on the job) and should be developed further

Agreement was found in terms of the assessment that those affected are more accepted today and that legal regulations on a company level support a more professional approach to those dealing with psychological issues.

In terms of weaknesses, deficits in general care were treated in a nuanced way. They referred primarily to the protracted and difficult access to care providers, the quality of offers, insufficient competence, the lacking qualification of (potential) allocators, and insufficient coordination between the system of provision and the workplace.

WEAKNESSES: SUPPORTING EMPLOYEES WITH MENTAL HEALTH ISSUES
Many deficits in general care, for example excessive waiting time for therapy offerings, poor quality and a failure to account for the work context and work conditions. Other problems mentioned include lacking coordination and the lack of exchange between service providers
For small to mid-sized companies, there are hardly any offerings available. The numerous, often excessively complex support offerings for large cooperation's are negatively influenced in their implementation by competition, for example among social insurance providers
The insufficient qualification of key external and internal service providers (general practitioners, primary care physicians, medical officers) delays effective, coordinated therapies and other interventions, thus promoting chronification
There is still a taboo placed on psychological illnesses in society and on the company level, psychological illness is individualized, and those affected are stigmatized. Those affected do not seek out help at all, or do so too late, often because they are afraid of loss
Knowledge about illnesses and the influence of working conditions is still inadequate, in society as a whole and on the corporate level
Goal conflicts within the company results for example from the fact that lower performance is not absorbed ad cannot be compensated by an increased workload

Conflicts of interest and goals that are carried out on the backs of those affected, limiting room for manoeuvre in dealing with them and generally influencing the importance of the issue as a whole, were mentioned on the one hand on a company level. These conflicts were revealed on the meta-level, for example, the inconsistent system of social law or the unidirectional assignment of problems to the health care system, and on the meso-level as well, for example, inside and between institutions and the umbrella organisation of social insurance providers. In this context, it became very clear that approaches and requirements go far beyond the individual company level and demand overarching debates as well as a political course of action.

26 participants responded on future opportunities, while 25 SWOT participants responded on dangers. In one of these response forms, only one opportunity was mentioned, while five response forms had the indication of a single danger. As a maximum, one SWOT participant from the group of service providers mentioned 16 opportunities and 10 dangers.

The total of 99 comments on future opportunities can be summed up in the following.

OPPORTUNITIES: SUPPORTING EMPLOYEES WITH MENTAL HEALTH ISSUES
The increasing pressure contributions to the continuing lifting of the taboo and sensitizes policymakers as well as other areas for the necessity to account for an "aging and increasingly diverse" society and the lifts of an increasing workload
Legal framing conditions on an (inter) national level
The health system has access to sufficient resources. For this reason as well, new concepts can be developed and paths of care pursed to achieve faster and long lasting treatment
A better exchange of information, transfers of knowledge, and networking between public/external service providers with internal actors complement this tendency
Flexibility in job design and the development of capacity-driven workplaces
The offerings of support expand in the course of improved collaboration between the social partners
The social partners and within the companies develop (new) forms of collegial support, the qualification and competence of the actors is expanded

Opportunities were seen equally in altered (legal) conditions and care offers, a progressive breakdown of taboos, an increasing awareness of the problem of the limits of increasing demands in all areas of life, the better coordination of services by the social insurance providers, and the increasing possibility to shape working conditions and workplaces in a way that is suited to individual capacities.

On the whole, it still seems unclear where the path will lead: future threats could result from policy-makers' ignorance, the lack of leeway to manoeuvre due to established structures in the health care system, or as a result of economic crises.

These overarching decisions on the course of future action were seen as having both a meso- and a meta-level and as potentially not only leading to stagnation, but also to a "roll back": this is clearly revealed by the following overview on the basis of 70 positions on future threats:

THREATS: SUPPORTING EMPLOYEES WITH MENTAL HEALTH ISSUES
Political inaction and "marshalling yards" between social security institutions amplify the problem
Socially and regionally based disadvantages in access to care providers are amplified, for example, by selective contracts signed by large companies. In addition, responsibilities are unclear and fragmented
Gaps in care, loss in quality, and additional uncertainty for those affected is the result, as well as a neglect of prevention by way of the one side focus on care aspects. Care deficits effectively block rehabilitation and amplify chronofication
Other dangers inhere in the medicalization of mental health problems, their trivialization due to increasing claims and rising cost, and the stigmatization of those affected, as well as privacy problems
The expansion of work time continues; consideration for those affected on a company level leads to the excessive demands on those not affected
Programmes and measures on a company level are primarily for the purpose of corporate image: for cost reasons, cooperation takes place with poor quality service providers
Professional integration is threatened; those affected are excluded and pushed out of the labour market

The majority of the suggestions to improve the support of employees referred to overarching strategies and decisions about the future course of action. Often, they were directed at the social insurance companies. On the company level, suggestions ranged across the entire spectrum from the company culture to the support for employees (not yet) affected. Here an overview of the suggestions:

SUGGESTIONS: SUPPORTING EMPLOYEES WITH MENTAL HEALTH ISSUES
Overarching suggestions
• Expand supporting legal conditions and develop political incentives companies and service providers
• Promote lifting the taboo and tackle stigmatization
• Promote interdisciplinarity in research and realizations
• Better networking of social insurance partners among one other and with other service providers in health care and in the companies
• Develop workplace consulting and sensitization of small to mid-sized companies
• Improve the coordination of exiting offers; establish an overarching institution to combine preventative activities
• Occupational health and safety
• Enable the implementation of legal provisions into concrete actions
• Sensitization and qualification (UVER) of company actors
• Strengthening participation in work protection
Focus on health care
• Policymaker's should approach the gaps in care provision and expand a network of care including ambulant psychotherapeutic offerings
• Reduce chronofication by way of early interventions based on disturbance in question, building up competence among care providers, better (regional) networking, and the like
• Develop new concepts, for example, for on-the-job therapies, incentives/compensation for the development and establishment of offers across institutions
• Offer low threshold advice for management, those affected, and other company actors
• Improve (regional) networking and inclusion of expertise and offerings in the companies
• On the level of the individual company
• Promote open communication, sensitization, and enable the early thematization of problems
• Provide helpful structures, processes, and low threshold offers
• Strengthen company contacts; provide training and support for management and other inner-company actors, coaching
• Promote the self-competence and responsibility of employees

Summary and Interpretation

Background of the Survey and the Participants

The SWOT analysis is a component of the Joint Action on Mental Health and Well-being. It was implemented in the framework of the Second European Health Programme by the European Commission and the EU member states from 2013 to 2015.

The goal is the development of a European frame of action to promote mental health at the workplace with the partici-pation of all relevant inter-company players in the field of health and labour policy. In addition, examples of good practice should be included.

The invitation to evaluate the national status quo by participating in the SWOT analysis was accepted by around one third of the institutions and individuals written to. The distribution of the total of 36 responses was very different, depending on field, as described above. Striking was the lower number of responses from ministries and relevant federal and state institutes.

Medical officers and psychologists made up a large portion of the SWOT participants. While the first group held managing positions at DAX firms, many of the psychologists worked for the social insurance providers. This should be kept in consid-eration in evaluating the results, when considering agreements in the assessments and (potential) areas of conflict.

Emphases and Response Frequencies

In Part I, both strengths and weaknesses as well as opportunities and threats in terms of the protection and promotion of health at the workplace were much more frequently and usually more extensively described than in part 2, which dealt with supporting employees with mental health issues.

An additional thematic emphasis resulted from the backdrop that the social insurance providers and social partners responded much more to Part I, while in Part 2 health care providers strongly shaped the overall picture. Reasons for this are surely due to the thematic emphases and insights into the problematic and respective strategies in the situation of care provision and practice.

Emphases that surfaced in Parts 1 and 2 are:

- Overall societal influences, trends, (legal) conditions, and their importance for the subject as whole, as well as for the support of those affected.

- Political importance, political strategies, the web of cooperation and competition on the layer of social insurance providers and other (inter) company service providers and their impact on companies.

- Extent, depth of implementation, quality, practicability of strategies, programmes and individual measures on an (inter) company layer and requirements and needs in this context.

Agreements and Discrepancies

A General Shift of Consciousness and Important Trends in the Transforma-tion of the World of Work

The lifting of the taboo on the subject of the psyche and the de-stigmatization of those affected within and outside of the world of work was often described as a consequence of the broad media attention focused on the subject of burnout, al-though this media coverage is seen as undifferentiated and imprecise. As a result of the demographic developments and in the context of the lack of skilled employees, the importance and acceptance of various forms of a new performance orientation and thus aspects of mental health are increasing. A general change in values in society and in reference to the world of work and the importance of work basically promote a sensitization for the issue as a whole and a pressure to act in various fields.

But respondents did not see this shift in consciousness as irreversible, suggesting that it could be put into perspective, for example, in the context of macroeconomic developments and their effects on the various environments. Already existing care deficits and conflicts over distribution could be seen, for example, in increasing problems in heath care allocation, stronger competition among (inter) company providers, and complex problems on the company level.

The (Legal) Framework, Additional Regulations and Incentives

In Part I in particular, the significance and influence of existing laws and additional bodies of regulation was reflected. A high level of agreement was found in terms of the basic importance of more widespread workplace health promotion and occupational reintegration management. Various positions were established on the role of risk assessment. They were basically rated in a positive light, while at the same time laws and other regulations were reflected on critically in terms of their formulation (depth of regulation), their degree of implementation and their realizability, and the meaning of (insufficient) incentives was rendered problematic.

In reflecting on the importance of further regulations, various assessments became clear ranging from their necessity to their being criticized as overly restrictive. With the example of comments on the "anti-stress regulation," the lines of argumentation ran analogous to "classical" lines of conflict among the social partners.

The occupational safety and health system in Germany was honoured in terms of its basic importance and for developments over recent years (modernization, perspective expansion).

The Significance of Different Groups

There was a positive consensus on the increasing interest on the side of policy-makers. Here, explicit mention was made of the demographics strategy of the Federal Government and a stronger prevention orientation in the Federal Ministry of Labour and Social Affairs' health policy and activities. Threats were seen as lying in the refusal to engage in additional political action and resource allocation: but both were seen as urgently needed. Several respondents suggested that there was a need for increased attention to the subject, across political parties and ministries.

In a purely quantitative sense, the comments made about the social insurance providers were much more significant. Here, the strategies and successes of the statutory health insurance system, the accident insurance system, and the pension insurance providers were honoured, and cooperation among them was pointed out. Frequently, individual programmes, projects, and instruments were emphasized, along with their significance for individual sectors and companies. But the responses also rendered problematic the negative effects that currently result or might arise in future from unclarified overlap between the social insurance providers. Several times, a further concentration was placed on behavioural prevention and an expansion of the "marketing orientation" within and between health insurance providers. Other aspects were pointed out as well: for example, an insufficient resource allocation and staff reductions led to a loss of qualifications among the responsible players and with the implementation of support offers at the companies.

Furthermore, medical officers and psychologists were already mentioned in part 2 as important professional groups and cooperation partners. The spectrum of comments stretched from a changed and/or changing behaviour (diagnostics, absence due to illness) to the greater accounting for changes to the world of work and subjects in the training programmes or in continuing education.

On the individual company level, mention was primarily made of management and leadership, those responsible for the field of labour and health protection and other groups (social consulting, workers councils, those affected and their colleagues). Among SWOT participants, emphasis was placed on a (necessary) change of consciousness, responsibilities, needs for sensitization and qualification and the adoption of expanded roles and tasks.

The strong expansion of a market for service providers and the (continuing) increase of actor groups were largely seen as risks and with (potential) lacks in qualification, in the quality of offers and instruments and a general "charlatanism."

Programmes, Strategies, and Collaborations

In Part 1 in particular, more than 20 years of experience with workplace health promotion and workplace health management were seen as a factor for success for a system-relevant and systematic approach. Many SWOT participants from the companies themselves indicated this and stressed generally positive collaborations with health insurance and accident insurance providers. Respondents found it sensible and basically feasible to integrate mental health into workplace health promotion and workplace health management and thus to support lifting the taboo and the stigma on all levels. Strategically speaking, they suggested that "troublesome, interest-driven trench warfare" could thus be avoided. Other opportunities were seen in workplace enhancement and in its increasing importance between and within companies. In Part 2, only one comment could be found in the suggestions towards improving support for employees with mental health issues that explicitly refers to "accompanying company offers (…) in the framework of workplace health management."

The joint target, the strategies in the framework of the GDA and the collaboration and events of psyGA were also emphasized in Part I as strengths and a concerted effort and the increasingly objective approach to the subject was seen as an opportunity. Here, targeted research funding could be continued and additional support offers developed for companies.

In the estimation of several SWOT participants, collaboration among the social insurance providers should be expanded further. Respondents suggested that political discussions influenced the degree of objectification and blocked progress. Along with individual company strategies and general aspects of service provision, additional (regional) collaborative efforts and networks were mentioned. They stretched from employee assistance programmes to optimized care structures for employees in crisis situations, including regional health care providers to well-structured networks of living environment oriented help on a municipal level. The weaknesses and threats include: recruitment difficulties among company medical officers, monetary incentives from companies to secure accelerated access to health care for employees, which is accompanied by an increasing scarcity of healthcare services in certain regions and increasing social inequality when it comes to taking advantage of offers.

Examples of Good Practice

SWOT participants largely expressed a positive assessment of the dissemination of examples of good practice and the possibilities of learning from the experience of others. Company and plant physicians provided various indications of what had already been achieved and pointed to additional areas of action. There was a broad consensus that the commitment on the necessary linkage of behaviour and relationship-oriented measures, resources for workplace health promotion and workplace health management with adequate structures and processes, the use of quality-secured instruments and the sensitization and qualification of internal and cooperating players are key foundations for a successful and sustainable approach to the subject at the workplace. But respondents also indicated that experience also shows how difficult the penetration, a promotion of use of possible offers and the cooperation of (affected) employees is, and how the activities are easily disrupted.

The respondents suggested that there are (too) many offers and instruments of various qualities available and they are often only tailored to large corporations. Internal company limits and dangers that can also be described as comprehensive include "aimless actionism" against one's better awareness and measures according to the "watering can" principle. In general, respondents saw other problems in the neglect of small and mid-sized companies in the lacking model function of public entities.

Other Areas of Conflict / Action

The SWOT results offer a broad spectrum of strengths and weaknesses, opportunities and threats. They point at the same time to "blind spots" in the representation and reflection on the current situation, and thus to possible future courses of action, fields of tension, and possible responses.

These include the acceptance that:

- Broad coalitions, networks, and strategies have not yet sufficiently led to an inter-professional dialogue and/or coordination and consensus in terms of expert terminology.

- Other key players have not included their estimations, knowledge, or experience at all in the SWOT, or only partially, although it is clear that there are many years of experience and expertise in the subject. In taking further steps, it could be worth thinking about the reasons for this.

- Referring to the need for and the exploration of interventions to promote mental health, already today a much larger part of the working world has been taken into consideration than is depicted in the results. This is true for the example of small to mid-sized companies in the field of health care and social service providers and for large organisations, such as hospitals, where ministries and social service providers, as legislators or clients, can often directly or indirectly help to influence the structure of the workplace and the quality of work relationships.

- A change in values and life plans is often secondary when social inequality is expanded, when people of a certain age, profession, or life situation are pressed into precarious work relationships and ignored entirely in terms of their health.

- Attesting to a dense web of cooperation and competition, key players could only emphasize that they themselves were a part of it, with all the conflicts of goals and roles, leeway for manoeuvre, limits and experiences of power-lessness that that brings with it.

- Challenges and necessary fields of action are revealed if results and experience are communicated in glossy publications and taken seriously.

The SWOT results included concrete individual suggestions and expressed the danger of experiencing a "rollback" that once again returns to ritualized conflict patterns, instead of transparently responding to resistance and thus providing a contribution to more credibility, resilience, and mental health on various levels.

HUNGARY

Joint Action on Mental Health and Well-being:
Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report: SWOT-analysis Hungary

1.1. What are the strengths of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?

Health Services:

- Screening test: mammography, lung screening, allergy screening, taking of a blood sample
- Annual mandatory inspection (ophthalmic testing, blood pressure measurement, chest auscultation) – aptitude test
- Health care insurance for their own employees
- Organized programmes: health days, health promotion events

Fringe benefits:

- Cafeteria System – SZÉP card: accommodation, catering and recreation
- Discounted recreational opportunities: swimming pool, gym, women's gymnastics, yoga (assessing the needs of the employees)
- Glasses compensation assistance
- Discounted holiday options

Healthy work environment:

- A large park and green area within the site (breaks during working time spent in the fresh air)
- To ensure working time relief for sporting facilities, participation in health assessment
- Indoor bicycle storage possibility (to permit access to the workplace by bicycle)
- Labour and fire safety training

Institutional services:

- Adequate advertising of workplace programmes organised by the employers: e-mail, posters, leaflets
- HR functions: annual/semi-annual anonymous evaluation, where everyone   has the opportunity to deliver an opinion on their colleagues and their working practices.
- Community: staff meetings, case conferences, department meetings
- Daily tasks group discussions, current tasks personalization, clear designation of responsibility for individual tasks, daily leader-subordinate relationship
- Statement opportunity for employees in the local press
- Prevention: training courses, skills development training, Williams Life Skills Program – stress management training
- Community building: annual team-building excursion

1.2. What are the weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?

From the employees' point of view:

- Lack of appreciation: uncompetitive income (existential insecurity)
- Limited use of the support tools (SZÉP card)
- Overload, uneven sharing of workload among the workers – less time for rest and relaxation
- Migration
- Poor connection between workers

Problems regarding work places:

- Excessively hierarchical system
- Irrational interests
- Personal distinctions
- Conflict management, lack of discussions
- Infrastructure deficiencies
- Communication problems: between employee – employee, employer – employee, employer – employers, etc. (in terms of the different management levels)

Work-related health problems:

- lack of capacity
- Testing: load-hours
- Occupational health services are often not in direct contact with the employer, and have no right to referral to a specialist
- lack of financial resources for this purpose
- It does not cover everyone (hierarchy)

2.1. Looking forward, what do you see as the main opportunities, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?

Health facilities:

- Professional service
- The normalization of relations between the occupational health and workplace leaders

Prevention:

- Burnout prevention training, communication training, Balint group
- Executive coaching, team building events (excursions, cultural programmes)
- Stress Management
- Taking in consideration the needs of person-related mental health: proper distribution of tasks within the working hours/rest time
- Sports and recreational facilities – Mental health promotion

Work opportunities:

- Accurate and regular information for the employees
- Advocacy groups, establishing forums
- The strengthening of the interaction between employer and employee
- Provide recreational leave
- The employment of mental health professionals in work places with over 500 employees
- Motivating managers (e.g. The recognition of the TOP 10 domestic nationwide organisations)

2.2 Looking forward, what do you see as the main threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?

From the employers' point of view:

- Lack of financial resources
- Not considering the importance of the problem
- The mandatory health requirements are not fulfilled (protective clothing – tool-glasses
- The devaluation of human resources: the employee only as labor

From the employees' point of view:

- Overload/stress, psychosomatic and mental illness, migration/attrition, burnout
- The disclosure of mental health problems leads to stigmatization (healthy vs. not healthy)
- Employees forced to work part-time jobs: workload is higher while work quality is reduced (especially in health care)
- Rivalry
- Indifference towards the community programmes

3. What would be your three most important recommendations for improving the protection and promotion of health in workplaces, particularly in relation to mental demands?

Preventive actions:

- Recreation, relaxation, exercise
- Leadership Coaching
- Stress/conflict management training prior to burnout
- Screening: concerning mental illness
- Bálint Group

Regarding workplaces:

- Financial support for professional development of the workforce
- Appropriate choice of leadership style
- The appropriate recognition of labour: financial, professional, ethical
- The work and rest timetable makeover

- Normalization of the relationship between workers and managers: problem solving, communication

- Searching for local options: The employment of occupational health physicians, occupational psychologists

- Risk analysis and risk assessment – risk reduction measures

- Quality management

- Employees informed about the possibilities

4.1. What are the strengths of measures currently taken to support employees who are affected by mental health problems?

- A lot of workplaces exclude the employment of these workers, for example: organisations that work without mental health intervention

- Usually the employer doesn't know that the worker has a mental health problem

Workplace perspective

- Further employment when the worker has mild mental illness

- First send psychologist, then psychiatric care

- Health care workers have an advantage over their workplace if they have mental health problems

- Social benefits, sports facilities

- Open forums where workers can tell their problems

Health care facilities

- Appropriate health care in case of problems

- Performing simple psychological tests

- Psychological counselling is available on site

4.2. What are the weaknesses of measures currently taken to support employees who are affected by mental health problems?

Workplace perspective

- The employer does not employ the worker who has mental health problems

- Will not be published

- Lack of capacity

- There is no systematic screening problem

- Workplace spiritual/way of life advice

- The most common reaction is layoffs

- Distrust of the employer (Can they do their work?)

Worker's perspective

- Colleagues did not dare to talk about their problems

- The worker did not dare to tell the doctor the problem

- The employer fired the worker if there is a lot of absenteeism

- Stigmatization

5.1 What future opportunities do you see with regard to the support for employees affected by mental health problems?

Prevention

- Screening – anonymously, psychological aptitude test annually
- Bálint-group, caseload
- Alcohol and drug addiction prevention programme

Employer's perspective

- Needs assessment of workers
- Employment of psychologist, internal mentoring programme
- Help in acute mental health problems: sick-allowance, support patient care, more vacation time
- Support for working with mental health problem: displacement, easier to work temporarily
- EAP: employee assistance programme, helpline, email
- Protected conditions, employment in the original workplace
- Leadership training, communication training
- Cafeteria programme: wider use by recreational programmes

5.2. What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?

Medical perspective

- Approaches rather see the medical aspect than the human aspect

Worker's perspective

- Stigmatization, feelings of helplessness and isolation
- Problems concealment, uncertainty, stress increases
- Too late for worker to ask for help
- Burn-out syndrome, suicide
- If the work cannot be done a lot of time without work layoffs

Employer's perspective

- Refusal by the employer and the colleagues
- Mentoring workload
- There is no organized approach
- More therapeutic direction, instead develop assisting helping management tools (coaching)

6. What would be your three most important recommendations for improving support for employees affected by mental health problems?

Worker's perspective

- Mentoring
- Own care service in workplace

- Supported psychotherapeutic care

- More holiday, part-time work, lighter workload

- Dissemination of knowledge about mental health problems (mental health problems vs. mental illness), tolerance

- Apply clear communication that health is success factor

- Recreational facilities in workplace

- Assessment of the needs and opinion of workers

- Workers are free to support policy

- Development of way: where to send these patients?

- Give financial support in illness caused by stress at work

- More resting time

- Reduce feelings of stigmatization

Health care facilities

- Regular and targeted screening (depression and anxiety tests), mental health investigation under-employment testing

- Stress management training

- Lifestyle advice

- Reduce feeling of stigmatization

ICELAND

Joint Action on Mental Health and Well-being: Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report: SWOT-analysis Iceland

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Low levels of injuries, relatively small work places, sense of community (small population)	Lack of a mental health action plan	Hopefully a mental health action plan in the making	That it might not be followed through
Highly functional unions; support physical activity, cancer screening, psychological treatment and continued education to name a few	More resources being put into rehabilitation (see VIRK later in the analysis)	Directorate of health working on health promoting workplaces	Increased instability in the labour market since the economic recession, job insecurity, temporary employment
Low rate of unemployment in the general labor market	• Few disabled people benefit from active labour market policies • Scarce opportunity for partial job placements because of limited ability to work • Hard to keep workers (at state/municipalities) when better wages/jobs are available	Administration on occupational safety and health (AOSH) is constantly working on promoting better work conditions	Long-term unemployment
Regulation against bullying in the workplace *http://www.gegneinelti.is/media/textaskjol/1000_2004_reglugerd_um_adgerdir_gegn_einelti_a_vinnustad.pdf*	Insufficient follow-up on compliance with the regulation	• Increase awareness and compliance which will reduce bullying in the work place • More knowledge and discussion on bullying in the workplace and its consequences • AOSH, Directorate of Health, VIRK and others	• Lack of resources to make sure that employers are complying with the law/regulation • High costs in resolving issues related to bullying in the work place which can be beyond the reach of many small companies.
Many small private enterprises are offering their services in health promotion in workplaces	• Economic crises • Insufficient follow-up to ensure quality of services	Hopefully a better economic situation will lead to more job opportunities	Danger of getting a group of in betweeners like in Finland (people who dropped out of employment during crises and when things are better younger/newly educated persons get the jobs and they stay on benefits/welfare)
Three ministries gathered and made a plan to tackle bullying in the workplace *http://www.gegneinelti.is/um-verkefnid/skyrslaadgerdaraaetlun/*	More focus on health promotion activities in schools than in workplaces	• Recognize good communication to know good communication • How about making a group that is ready to answer impoliteness online by complementing and encourage where is reason to • Increased awareness about health and safety at work • Possibly more focus on workplaces on the horizon	• More focus on workplaces, online bullying (among adults and children) • Increased instability in the labour market since the economic recession, job insecurity, temporary employment

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
New special services to follow up with people with mental health problems in the primary health care *http://www.heilsu-gaeslan.is/onnur-thjonusta/gedheilsa-eftirfylgd/*	• More demand than supply – increased waiting time • Invisibility • Cutbacks in the administration of occupational safety and health	• Increase promotion for this programme in primary care. • Increase access to CBT clinics • Increase access to psychologists in primary care • More education and interventions in the workplace, more prevention, i.e. more flexibility, focus on getting up and move regularly, look at canteens, access to fruits	• Continuing cutbacks in the health care system • invisibility
Maternal and child health services (which have high coverage) visit parents with a new-born and evaluate home situations	• Cutbacks in primary health care		
FMB – joint project between the psychiatric unit and maternal- and child health unit at the university hospital, Landspitali. For parents with psychiatric illnesses that are expecting a child or have a child under 12 months. Help with attachment issues *http://www.landspitali.is/?PageID=16572*	• More follow up needed • More services for fathers needed • More focus is needed on women who have history of substance abuse	• Further development with this programme • Reach a wider group	• Continuing cutbacks in the health care system • Hiring freeze at LSH
Work with support (AMS) at the Directorate of labour *http://www.vinnumalastof-nun.is/atvinnuleitandi/atvin-na-med-studningi/*	• Supports a narrow group (mostly the developmentally challenged) • Lack of research on efficiency to continue development	Increase support for a wider group with impaired work abilities	The employment market is not open enough
Good educational system in Iceland	• People are often young when they are diagnosed with a psychiatric illness and therefore do not finish higher education • Rigid loan system for university studies, i.e. no student loans if you are not a full time student		
Increased awareness among enterprises (and especially larger enterprises) on the importance of health and safety at work			
Directorate of health is working on health promotion in the workplace, in accordance with other health promoting projects, such as health promoting schools (three school stages, 2–20 year olds) and health promoting community		Establishing a Healthy Workplace network in Iceland	Funding

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Healthy School network (both for students and employees). Risk evaluation including evaluating work related psychosocial factors is mandated			
Many workplaces do annual workplace surveys – in order to monitor employee satisfaction and attitudes towards their work and management	Less interest in taking part – as the survey is done annually	Make action plans to improve companies, adjust work organisation to employees needs and increase social support	Many action plans are not followed through
	Less hiring – leading to more demands on existing employees		• More burnout and more sickness absence (because of more work related demands) • More supply of workers leading to those who are more vulnerable being let go
Capacent consulting company gather annually (Ánægjuvogin) information from employees in companies regarding work satisfaction, attitude towards unions. Measure – best companies		Easier to monitor which companies are treating their employees well – where there is higher job satisfaction	Survey used in order to promote company instead of taking care of the employees
Strong welfare system, low-cost medical care for patients, health promoting initiatives (especially regarding physical activity)	Psychological treatment is expensive (not official part of health care), lack of understanding of the importance of psychological stress as a risk for negative health outcomes, lack of initiatives aimed at increasing mental health	Increased awareness about the importance of mental health regarding physical outcomes (and hence opportunity for employers to lower cost (absence from work)	Budget cuts. Increased mental disorders (stress, depression) among employees/the population following the economic crises.

What would be your three most important recommendations for improving the protection and promotion of health in workplaces, particularly in relation to mental demands?

Systematic psychosocial risk analysis in workplaces and follow-up procedures in order to limit risks and increase mental well-being in workplaces
Better management quality and more professional human resource management
More tolerance and understanding towards people with mental illness in the job market – need to provide more job opportunities
Better procedures regarding return to work after mental illness period
Provide information on early symptoms on mental health problems to employees, along with simple actions.
Create a mental health policy for the workplace – with the aim of increasing mental health (measurable goals, etc)
Provide access to mental health support if needed

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Sick leave benefits through unions (and through social insurances when the union benefits run out)	Less right for those who have no or insufficient working history	Increase education both for employees and employers	Icelanders are more negative towards employment of people with mental health problems and mental retardation than people with other kinds of disabilities
• Work rehabilitation fund to help people get back to working or keep them from dropping out of work due to sickness. • *www.virk.is* New laws in 2012 about set donations from employers, pension funds and the government (37 % of clients are there because of psychiatric problems)		• Promote work rehabilitation in accordance with other systems • More wholesome services for individuals with impaired work abilities • Increase help for those who are at risk of dropping out of the job market	• Of people who are on disability due to mental illness, 40 % have nothing to do during the day • The fund might not reach all who could benefit from work rehabilitation • People with mental illness may be at risk of going on permanent disability pension and not return to work after long term sickness absence
Directorate of labour has a special programme for young people with mental health difficulties, it aims at getting employment and keeping it	Directorate of labour is experiencing big cutbacks this year, the influences are yet to be seen	Mental health issues are being more openly discussed that before • Increase knowledge about resources	Still prejudices
Directorate of labour also sponsors people to take certain classes to increase their opportunities of getting employment (i.e. computer skills and such), they also have a longer term programme of education	Sometimes involvement with people who are long term unemployed is much to late	• Increase availability of courses and educational programmes that are sponsored by the government • Encourage those seeking employment to be more active with special projects, i.e. better computer access	Not everyone is seriously invested in the educational programmes they attend
The ministry of welfare put together a group, "Welfare watch", in early 2009 to monitor people's situations following the economic crises. It has monitored employment, issues regarding children and interpersonal violence amongst other things *http://eng.velferdarraduneyti.is/media/velferdarvakt09/29042010The-Welfare-Watch_Report-to-the-Althingi.pdf*	More opportunities for rehabilitation are needed and special support into the homes in some cases.	The majority act from 1997 is under revision so that instead of a family member having to ask for a patient to lose his autonomy it will be in the hands of social services or doctors *http://eng.innanrikisraduneyti.is/laws-and-regulations/english/legal-competence/*	
More focus on work rehabilitation and more funding for it	We need more people educated in the field	Early intervention – lower the incidence of disability	• Much needed – fast growing trend in work rehabilitation • Dissatisfaction with the cost amongst some of those that pay for the fund
Active workplace project (virkur vinnustaður). Systematically create an absence policy, to lessen absenteeism and help people back to work after long time sick leave (4 weeks or more) *http://www.virk.is/is/virkur-vinnustadur*			

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Many companies are developing sickness absence policies to monitor and limit sickness absence	Sickness absence policy may not accommodate well enough those with mental disabilities	Follow up and more understanding that is not necessarily therapeutic/health promoting to stay home on sick leave – working can be health promoting in itself	
	Lack of motivation, lack of time		
More intensive rehabilitation for i.e. fibromyalgia, depression and more	Long waiting lists, have to take extensive sick leave (which they must have earned)	That it becomes a norm that people can take extensive sick leave for rehabilitation	
Rehabilitating educational opportunities for people on long term unemployment or sick leave	Monetary issues	Education through the school systems to normalize mental health problems to avoid stigmatization	

What would be your three most important recommendations for improving support for employees affected by mental health problems?
Focus and resources on early intervention to keep people in employment
Follow up for those who have been hospitalized or on sick leave
Family therapy – prevent that social problems are inherited through generations.
Increase education in the work place for individuals as well as companies

IRELAND

Joint Action on Mental Health and Well-being:
Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report: SWOT-analysis Ireland

1. Description of the national SWOT Process

As part of a project on mental well-being at work (Joint Action on Mental Health and Well-Being) being implemented within the framework of the 2nd European Health Programme of the European Commission and the Member States of the EU in the period 2013 to 2015, the Health and Safety Authority (HSA) Ireland, a state agency under the remit of the Department of Jobs, Enterprise and Innovation (DJEI) early in 2013, became an official Collaborating Partner in this Europe-wide exchange to improve the services for improving mental well-being for employees.

The Authority's central aim is to develop a national as well as a European framework of action to promote mental health at the workplace, with the participation of all company and non-company actors both in the field of health policy and that of labour policy (governmental bodies, social security actors and social partners) as well as those with a remit for these areas, working within organisations.

To inform the framework, the Authority took responsibility – through its Organisational Psychologist/Labour Inspector in the Occupational Health Unit – to gather information and build up a reliable evidence base on the strengths, weaknesses, opportunities and threats pertaining to this area, in Ireland currently.

To this end, the Authority hosted a series of meetings throughout 2013 in order to invite relevant stakeholders to exchange views and positions and reach a synthesis on the topic. At these meetings, invitees carried out analysis of the Irish systems and procedures governing mental health at work, and instigated an analysis for various causal factors and mediating factors for mental ill-health improvement at national level. In order to ensure that all assessments could be combined in an efficient manner with those of other experts and practitioners and to limit the effort for all those concerned as far as possible, this information survey was conducted using the template in the form of a so-called SWOT analysis (S = strengths, W = weaknesses, O = opportunities and T = threats). The result is a record of Irish expertise and best practice, as well as insight into harmful practices; and a current and informed Irish evidence base.

Up to thirty relevant stakeholders participated, either by attendance at meetings of groups, one-on-one meetings or through using the SWOT template provided. Meetings were held at the Authority HQ in Dublin, and in some cases, on site at the location suitable to the stakeholder. A list of stakeholder organisations can be found in Appendix 1.

2. Health and specifically Workplace Mental Health in Ireland

Ireland is an island to the west of Europe and has a population of 4.6 million people, according to the most recent census data. This represents an 8 % increase since 2006. The population living in Ireland is increasingly diverse. The latest census data shows that the number of people living in Ireland who were born outside the State increased by 25 % to 766,770 in the period 2006 – 2011. This now represents 17 % of the population. People living in Ireland are now living longer than they previously did, but not all are living those longer lives in good health. Many people living in Ireland and their families are affected by chronic diseases and disabilities related to lifestyle issues; poor diet, smoking, alcohol misuse and lack of proper physical activity. Enjoyment of health is not evenly distributed in society, with prevalence of chronic conditions and accompanying lifestyle behaviours being strongly influenced by socio-economic status, levels of education, employment and housing.

As reported in Healthy Ireland, a framework for improved health and well-being 2013 – 2015, which is a whole of government approach to improving health in Ireland, chronic conditions are responsible for a significant proportion of premature deaths. The prevalence of conditions which have an association with mental health – either uni-directionally or bi-directionally – such as hypertension, coronary heart disease, stroke and type-2 diabetes increases dramatically with age, is greater in lower socioeconomic groups and generally higher in males. By 2020, the number of adults with chronic diseases will increase by around 40%, with the older age cohorts begin more vulnerable to more of the conditions and more severe versions of the conditions.

The number of adults with diabetes is expected to rise by 30 %, from 2010 – 2020. The number with chronic obstructive pulmonary disease by 23 %, the number with hypertension by 28 % and the number with coronary heart disease by 31 %. Cancer is the second major cause of death in Ireland, after cardiovascular disease, accounting for over 8,000 deaths per annum with an average of nearly 30,000 new cases of cancer diagnosed yearly. The number of newly diagnosed cancers is increasing by 6 – 7 % annually and unless a major reversal of trends occurs in the near future, the number is likely to double in the next 20 years. The underlying risk of developing cancer is increasing by less than 1 % annually and the ex-

pected increase is primarily due to the higher proportion of elderly people in the population but may also be influenced by the projected growth in the total population. This is the biggest predicted rise in the 27 EU Member States. Physical ill-health is inextricably linked to mental ill-health for suffers, and also has ramifications for families, carers, the public health system, communities and broader society.

Defining Health, Well-being and mental health

Health means everyone achieving his or her potential to enjoy complete physical, mental and social well-being. Healthy people contribute to the health and quality of the society in which they live, work and play. Health is much more than an absence of disease or disability, and individual health and that of the country, affects the quality of everyone's lived experience. Health is an essential resource for everyday life, a public good, and an asset for health and human development. Since the term "mental health" is used in very many, partly differing definitions and concepts, we are using it when organising the exchange of experience with the following definition:

- Measures taken to protect and promote health at the workplace where there are mental loads: this is taken to mean measures of company-based and non-company-based occupational safety and health as well as measures of workplace health promotion.

- Measures taken to support workers affected by mental health problems: this includes measures of in-company integration, gradual re-integration, company-based and non-company-based social advice, as well as measures concerning general, company-based and non-company-based health care.

Mental demands may arise from factors of work organisation, the organisation of working hours and tasks and the social relations at the workplace, such as frequent disturbances and interruptions to the work process, health-harming shift schedules, great pressure of time, a poor working atmosphere and lack of recognition. (The term "mental demands" is used in a neutral sense in work science, and to aid understanding we use this term in the sense of the ergonomic term "inappropriate load" in this project).

Well-being is an integral part of this definition of health. It reflects the quality of life and the various factors which can influence it over the course of a person's life. Well-being also reflects the concept of positive mental health, in which a person can realise his or her own abilities, cope with the normal stresses of life, work productively and fruitfully, and be able to make a contribution to his or her community. Consideration of health and well-being requires a shift in focus from what can go wrong in people's lives, to focusing on what makes their lives go well.

The Health Service Executive (HSE) under the Irish Department of Health has a strong input into mental health services generally and provisions nationally. The HSE National Office for Suicide Prevention *(www.nosp.ie)* as part of the *"Your Mental Health"* awareness campaign, which aims to improve awareness and understanding of mental health and well-being in Ireland, considers this is particularly important in the present economic climate with increasing financial pressures, job losses and other personal difficulties which arise due to recessionary times. The Office offers advice and assistance on:

- Alcohol & drugs support

- Depression support

- Eating disorders

- Bipolar & other personality issues

- Self-harm & suicide support

- Bereavement & loss counselling

- Bullying & harassment services

- Relationship problems

- Sexuality

- Financial worries

The HSE provides a wide range of mental health services nationally, in community and in hospital settings. On the main HSE.ie website Mental Health Section, Mental Health service detail are provided, health professionals who provide them are listed, and other topics like counselling and suicide prevention are also discussed nationwide.
There are a multitude of counselling, advocacy, support, advice and resource bodies, from the state, voluntary, community and private sectors.

Taken from *Healthy Ireland – a framework for improved health and well-being 2013 – 2015 (p 10)*

Mental ill-health is a growing social and political, as well as economic issue and it is expected that depressive mental illnesses will be the leading cause of chronic disease in high-income countries by 2030. One in every four people (25 %) will experience mental health problems during his/her lifetime. Mental health problems have huge personal impacts on those who experience them, and result in significant costs related to loss of productivity, premature death, disability, and additional costs to the social, educational and justice systems.

It is estimated that the economic cost of mental health problems in Ireland is € 11 billion per year. The economic crisis is expected to produce secondary mental health effects that may increase suicide and more Irish young people die by suicide than in other countries. The mortality rate from suicide in Ireland in the 15 − 24 age group is the fourth highest in the EU, and the third highest amongst young men aged 15 − 19.

One in 20 of participants aged over 50 years in an Irish longitudinal study on ageing (TILDA) reported a doctor's diagnosis of depression, with a similar number reporting a diagnosis of anxiety.

Levels of depression and admissions to psychiatric hospital are higher among less affluent socioeconomic groups. Mental health problems are also related to deprivation, poverty, inequality and other social and economic determinants of health. Economic crises are, therefore, times of high risk to the mental well-being of the population and of the people affected and their families.

Health comprises the second largest component of public expenditure in Ireland after social protection. From 2000 to 2009, the Irish public healthcare spend more than doubled in real terms to € 15.5 billion per annum. Spending is mainly directed towards diagnostics and treatment services for diseases and injury. Chronic diseases and their risk factors are major drivers of healthcare costs, as well as associated economic losses.

Obesity presents a real clinical, social and financial challenge which could have a detrimental legacy lasting decades, the scale of which is only starting to emerge. The annual estimated economic cost of obesity is approximately € 1.13 billion. Alcohol is responsible for a wide range of health and social harms; dealing with the consequences of its use and misuse places an estimated burden of € 3.7 billion annually on the resources of the State. Mental health problems have huge personal impacts on those who experience them, and result in significant costs related to loss of productivity, premature death, disability, and additional costs to the social, educational and justice systems. It is estimated that the economic cost of mental health problems in Ireland is € 11 billion per year. The economic crisis is expected to produce secondary mental health effects that may increase suicide and alcohol related death rates.

6 − 15 % of the total health budget is spent on treating tobacco related disease – this amounts to between € 1 − 2 billion every year. In 2008, smoking attributable diseases accounted for an estimated € 280 million in hospital costs alone. There are also significant productivity losses due to excess absenteeism, smoking breaks and lost output due to premature death.

3. National level SWOT Analysis findings

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Immediate appointment with health professional – occupational health nurse when needed (3 days)	Still some stigma/suspicion re visiting Occ. Health in any company	Have more invited expertise into actual workplaces/on site to deliver messages of health promotion	Shift work – should be fed into on medical/occupational health (epilepsy etc.)
Occupational Health nurse status/role is well used and trusted in many organisations amongst managers and staff	GPs – certifiable illness for s.p.s – "a medical condition" can be used "Anxiety/Depression" on certs, managers have to be told. GPs "too inclined to medicate"	Focus on cyclical mental health issues: • Sept/Oct – SAD • Christmas etc. Have times focusing on general bodies/organisations. Get them to take a stand with awareness/ seminars etc.	GPs lack of training or exposure to mental health expertise/best practice
• Natural private health programme targeting employees and EAP • Increased awareness throughout health promotion activities of what's out there		National Suicide Awareness Day – have a workplace day	
Workplace can be a very supportive environment for people due to social aspect of it; networking, friendships etc.		Human face as point of contact Managers to not pass over issues which are difficult to deal with, labelling them mental health when they are not	
Materials are important; notice boards, Induction awareness training for all new staff, good information given	If no management or HR support, programmes will be much less effective	Ensure everyone knows of all facilities and services that are there for them	For longer term illness, return-to-work systems should be targeted/improved. Recession/ productivity demands etc., make this harder to resolve
Medical accent supports built into work systems – free GP scheme in some organisations, very helpful for general health	Lack of management training in some organisations in the area of mental well-being and psychological health	Partnership with HR and Occupational Health and Management made stronger and more formal.	
		Facilitating the separation between mental health and illness, and general well-being should be focus going forward	

What would be your three most important recommendations for improving support for employees affected by mental health problems?
Focus and resources on early intervention to keep people in employment
Follow up for those who have been hospitalized or on sick leave
Family therapy – prevent that social problems are inherited through generations
Increase education in the work place both for individuals as well as companies

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands? (whether still at work or not)		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Will be seen in 28 days by CMO	28 day wait to be seen (in some occupational groups)	Increase quality of training and development for managers of people/teams/depts. re mental health	Person-job fit problems inherent, which will pose more problems as time passes
Good rostering system which is person-friendly	Some managers don't progress mental health issues to the CMO due to trying to "protect" staff	Pragmatic, easy-to-use procedures should be in place for mental health issues early on	Age-related mental health issues intrinsic in the job
	Too early return to work without attending to mental health issue	Regular use of standardized questionnaires across different industries to getting known stresses should be used regularly	Increased reports of stress in order to move away from front line exposure
Very clear system for mental health issues (once the person is captured within it)	No really reliable criteria for "work-caused" re mental health		GPs differ in how they categorize and diagnose mental health issues, over diagnosis of PTSD
Good peer support system for "one-off events"	Many "fit for work" issues confounding the area Hard to get real cause	Develop wellness programmes and link to benefits/rewards	
Some good record keeping to inform policy decisions	Lack of consistency in how systems are applied nationally		Increasingly violent culture so more exposure to stressful events by employees
Good restricted return-to-work structures in place	Pay for absence which is work-caused means employees are rewarded for indicating mental health issues work-caused when they may not be		
	Compensation Act and legislation makes the area fraught and contentious		
EAP Counsellor referral CMO Peer support; • Acute events • Gardaí	• Cost/funding • Management support for employees • Lack of training on how to deal with issues • Lack of contact		
Specialist referrals	Difficult to categorise IOD Fear of confidentiality		

1. COMMUNICATING/INTERPERSONAL RELATING

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Legislation and policy	Management training	Implementation policy	Absence/Presence Personal Injury

2. RECESSION ISSUES

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS/RISKS
Collaborating with various stakeholders	Uncertainty	Innovation	Fear: Job/Pay loss

3. CRITICAL INCIDENTS

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS/RISKS
Collaborating with various stakeholders	Uncertainty	Innovation	Fear: Job/Pay loss

4. WORK TASK ISSUES

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS/RISKS
Work valued generally	No burnout prevention system	Technology/innovation could be used better	Low productivity when people are not mentally well

5. CHRONIC ILLNESS

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS/RISKS
Empathetic population/culture	Exclusion/intolerance	Appropriate rehabilitation should be developed with a work orientation	Blame/stigma of mental health

6. INDIVIDUAL/PERSONAL RESILIENCE ISSUES

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS/RISKS
Informal help	Stigma	Supportive measures	Stress/absence/burnout

7. NON-WORK ISSUES

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Health service	No link up	Link mental health and work	Stress/absence/performance

8. LACK OF APPRECIATION FROM SUPERIORS

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
	Employer expectations	Supervisor training	Low retention

9. BOREDOM/UNDER STIMULATION

What are the strengths and weaknesses of measures currently taken to support employees who are affected by mental health problems?		What future opportunities and threats do you see with regard to the support for employees affected by mental health problems?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS/RISKS**
Good research	Productivity impact	Coaching	Disengaging – unemployment

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Occupational Health legislation Equality legisltation	• No resources • No requirement for occupational health services • Certification • SMEs	• Interdepartmental public health framework • Reform of certification • Early intervention • Return to work interview	Stigma
		• Health surveillance • EAP • Integration • Coalition • Workplace as part of the solution	
Wealth of policies and guidance available	Consistent application of policies	Early intervention – reduce absenteeism	
General awareness of the issue has increased (societal awareness)	Organisational understanding of issues is mixed	Supports/assistance	Conviction that people are genuine
Good, positive management can help (if early)	Poor line management (handling these issues)	Training and awareness	Training could be theory only Budget
EAP – proactive	Measuring effectiveness – cost		

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
• Eap services • Policies/procedures • Legislation/resp/acc • Early intervention • Awareness/openness	• EAP services – reviewed/updated • Stigma associated with mental health • Lack of engagement & communication	Improve absence management and return to work training	• Ongoing stigma • Not prioritized
Work/life balance Management open to support	• Lack of training at line management level • Fractured approach – stress/bullying • Holistic approach	• Promotional programmes • Workplace tool review – only workplace issues	Lack of responsibilities No budget
	• Absence management – connection • Back to work integration • Training	Management KPIs	Economic climate
	Language	Performance management EAP to be updated	
• Plans/protocols • Documents • Legislation on discrimination • Good practice on prevention and promotion in some areas (large organisations/public sector)	• Training/lack of training to deal with mental health problems (fear of tackling) • No legislation addressing bullying/stress • Lack of management before crisis (pro-active)	• Training – managing change • Specialist support (on-site support or access to it externally) • Mediators • Regular reviewing/earlier intervention • Upward feedback, more indirect – line manager not dealing straight with supervisor	• Discrimination • Resources/costs • Lack of time (pressures) • Change (without ability to compensate) • Time management • absenteeism • Aggravated by sick leave changes etc. • Job/skills loss
• Professional support • Part time/flexible working arrangements • Organisationally driven • Good response to incidents	• Not immediate • Poor change management/consultation • Spillover of pressures into family life • Workload not reduced • Poor prioritization of demands	• Better communication • Greater employee involvement/control • Learning across organisations • Risk management – identifying psycho-social risks (more focus on physical)	Increase risks of accidents/conflict
	• Considered less committed if take these up • Less statutory commitments • Longer term impact if not dealt with • Lip service but not resourced		
• Encourages competition • Benefit system/welfare	• Discouragement • Poor transition to new jobs • Lack of investment in job training • No support for those in jobs	• Open opportunities for discussion • Often over-estimated • Help temp employees with future prospects • Support people want to move jobs • Skills development	
		Learning between public and private sector	
• Work/life balance policies • Legal framework	• Eroded by current economic/work conditions • Lack of enforcement	• Guidance produced on Mental Health in the workplace by: • ILG • WHO • HSEUK • MHC Canada	• Stigma • Prejudices • Attitudes

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
• Work/life balance policies • Legal framework	• Eroded by current economic/work conditions • Lack of enforcement	• Guidance produced on Mental Health in the workplace by: • ILG • WHO • HSEUK • MHC Canada	• Stigma • Prejudices • Attitudes
• Health Promotions policies and procedures • Occupational Health Services • EAP • Positive organisational culture (early interventions supports, policies, training and workplace practices)	• Lack of engagement by those who need most to avail of them • Overuse of medication vs psychosocial supports • Lack of trust by employees re confidentiality, disclosure, stigma • Lack of self-disclosure		
• Different types of training • Programmes to build workers' resilience to stress	• Lack of specific mental health policies among employers • Policies are not implemented • Lack of training or bad quality • Too narrow/basic need to focus lifestyles as well not widely available		
• Equality legislation • Reasonable accommodation • Return to work policies • Flexible work arrangements • Return to work grant by FAS	• employers not aware that equality legislation applies to mental health • HR do not know how to deal with mental health issues • Lack of training for line management • Lack of community based case management		• Adversarial approach to compensation • Lack of self-disclosure
• Communication • Relationships	• Not used as reasonable accommodation • Not being used by employers • High expectations from management • Lack of understanding of organisational ethos		• financial worries • high job demands • discrimination
	• Introduction of changes • Lack of feedback/training and education • Absence of dedicated team (person) for training and support		
Social Welfare/Benefit System/Government Training System	• No support when moving jobs or thinking of moving jobs. Particularly for those on short term contracts or temporary positions	Help insecure (those on short term contracts/temps) employees with up skilling	Recession
Existence of work/life balance policy	Eroded by economic and working conditions	Increased/Introduction of Occ. Health Services	Overuse of medical model & lack of solutions on a psycho/social interventions
Good legal framework	Not enforced/monitored		

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Mental Health Promotion Program	Lack of engagement by those who need it – both employees and managers/employers	Referencing Mental Health documents/policies from other jurisdictions & building on them	• Stigma • Attitude towards mental health • Societal approach to mental health
Positive organisational culture	Lack of trust by employees that information provided will remain confidential		
Mental Health/equality training	Quality of training is often questionable		Adversarial approach is not beneficial
Equality legislation provides for reasonable accommodation for those with a disability such as mental illness	• Lack of specific policies/ policies are over arching • HR/Employer etc. not aware of inclusion of mental health in this legislation. • HR/Employer not aware of what "reasonable accommodation" is • No community based return to work services for those out of work due to illness	• New Interdepartmental group set up under remit of Dept. of Health • Need to work together (multi agency approach)	
Wealth of policy/procedure/ guidance material	Lack of consistent application of policy	Early intervention/knowledge of managers	Stigma of early disclosure
General awareness of mental health issues in society has increased	• Organisations understanding of issues vary • Absence of training for direct managers	• Portraying benefits of providing support and assistance to managers/employers • Positive managers with understanding of Mental Health issues	• Organisational culture particularly around validity of claims • Personal ownership by employee
EAP	Measuring effectiveness		
Legislation – accountability of employers/managers			
Greater awareness of prevalence of mental health difficulties in society generally	Challenging business environment can cause important areas to slip out of priority	The realization by organisations of the win-win that exists for individuals and employers when employees health and well-being is considered	Fear of making a situation worse
Concerted stigma reduction measures in the national press including a specific focus on the workplace	Fear of the unknown, a lot of unease and uncertainty about "mental health"	The realization of the benefits for individuals and employers when people feel it is safe to disclose a mental health difficulty	Perceived associated costs
	Difficulty that individuals still have discussing mental health regardless of campaigns to promote health and well-being generally		Other business priorities taking precedence at a given time
			Multiple challenges for all citizens in all aspects of work and non-working life which add to demands

What would be your three most important recommendations for improving the protection and promotion of health in workplaces, particularly in relation to mental demands?

Awareness raising campaigns to provide individuals with the tools to support and maintain their mental health and well-being and promotion of individual responsibility for own mental health and well-being using the tools at their disposal

Management training to ensure managers are in a position to support their teams and the balance of mental demands

Open communication and culture to enable discussion when there are difficulties before they become major issues

What are the strengths and weaknesses of measures currently taken to protect and promote health in workplaces, particularly in relation to mental demands?		Looking forward, what do you see as the main opportunities and threats, affecting the protection and promotion of health in workplaces, particularly in relation to mental demands?	
STRENGTHS	**WEAKNESSES**	**OPPORTUNITIES**	**THREATS**
Measures have tended to take various forms such as awareness raising campaigns of the importance of looking after your mental health and well-being – these have helped open up communication with a shared language	Fear of disclosure in the workplace according to research appears to still be a major concern for some employees	Greater awareness around this topic and its prevalence is focusing employers' minds on the topic. At 2 recent seminars we ran on mental health, very limited promotion filled the events	Many employers feel overwhelmed by the topic and unclear where to start or what to do
Some have engaged in campaigns explaining where assistance is available e.g. EAP or HR – this has had the benefit of stigma reduction and again opening up communication in the workplace	Measures not communicated well to employees	Promotion of the business case for addressing such problems early could encourage greater participation	A fear of "opening a can of worms" can hinder the initiation of any supports
Others have provided training for line managers or HR personnel on supporting individuals with mental health problems – this has been invaluable as it deals with the often irrational fear factor felt by individuals feeling ill-equipped	Concern on behalf of employers of what may emerge if too open regarding this topic	Initiatives such as this Joint Action on Mental Health and Well-beeing and strategies such as See Change's stigma reduction campaigns	
	Partial supports but against a back-drop of poor communication/unsupportive culture	Development of tools and supports for employers could facilitate greater dissemination of supports for employees and attend to the concerns of employers who feel helpless with regards mental health	

What would be your three most important recommendations for improving the protection and promotion of health in workplaces, particularly in relation to mental demands?

Have a clear policy and procedure communicated to all staff and managers regarding how one engages with whatever supports are available from the employer and who to approach. This would take some of the "unknown" out of the situation for all concerned and may encourage disclosure

Training and guidance in particular for line managers regarding supporting their teams in the case of a mental health difficulty, what steps they need to take to access employer supports and where they need to go for assistance

Communication and open discussion around mental health and well-being

4. Qualitative interpretation/ key learnings on national level

Generally agreed STRENGTHS

- Work can be beneficial, and the benefits of work – social, financial and psychological – should be emphasised.

- Generally people are well meaning and the stigma of mental health issues has reduced.

- Legislation in the area of equality and health and safety as well as disability rights has improved matters.

- Increased awareness of mental health issues and normalisation of mental health problems has increased tolerance and acceptance of mental health as an important component of health.

- There are many voluntary agencies which are oriented towards support and assistance for people with anxiety, depression or other mental health related conditions.

- There are state payments for illness and disability which means those with diagnosed mental health impairment have financial entitlements.

Generally agreed WEAKNESSES

- There is not any legal defining concept of psychosocial risks at work, mental health injury, stress as injury in National, European and International legislation.

- Not all interactions at work are within the employers' responsibility/under the employers' powers.

- Psychosocial hazards (defined by the International Labour Organisation (ILO, 1986) as the 'interactions among job content, work organisation and management, and other environmental and organisational conditions, on the one hand, and the employees' competencies and needs on the other) refer to those interactions that prove to have a hazardous influence over employees' health through their perceptions and experience yet perception and experience are outside the aegis of the employer/manager.

- Many of the employers' management powers are specifically subjected to labour law rules and collective bargaining and not to OSH legislation.

- Within the OSH legal framework, work-related stress is commonly accepted by all countries and it is sometimes the only reference in psychosocial risks. Ireland has included a reference to HSA tools for auditing work-related stress (Work Positive) other national guides but Stress, specifically workplace stress – as it is not an "illness" – is not reportable to any authority nationally.

- Management of many mental health matters falls within the familial or personal sphere and it would be outside the scope of the employers' management powers.

- Non work issues affecting mental health infringing on work are very important and should be included. Although various sources of problem may be outside of work, the remedy/possibly supports may be at work in form of help/assistance and the impact of the stress will of course be at work, where effects can include, as agreed by the group, conflict, fatigue, proneness to short temperedness or highly volatile behaviour as well as behaviour which might lead to accidents.

- Discrimination based on personal identity, race, religion or any one of the nine grounds (and others not specified in equality legislation) is a source of stress which the group agreed, should be highlighted independently of other sources. Identity based bullying/discrimination and harassment are very live issues, it was agreed and important as stressors in a separate category from other less focused or clear-cut behaviours.

- Organisational culture can filter down to all levels, leading to a fear of "bucking the trend" and requesting changes. It is often seen as easier to comply, despite adverse effects on mental health, due to fear of losing job/ alienation. This is more so during a recessionary period.

- Job demands was generally agreed as a primary source of workplace mental health problems. This includes the task demands, the complexity and or newness of those demands, and the work – life balance potential or reality for that job.

- Whilst it was agreed that there was limited strength in terms of policies, Occ health systems, health promoting systems and legal frameworks, it was discussed and thereafter agreed that in effect there was not enough legal infrastructure in place to give weight to the framework existing – in each of health and safety, IR and equality.

- There is a fractured approach in Irish society, to issues surrounding mental health. While at community level there are some positives, and the public health system can be appositive experience, there is not enough synthesis , and this often leaves the individual with no real anchor whilst experiencing the mental health problem.

Generally agreed OPPORTUNITIES

- Lack of training for management/employers on how changes in personal circumstances can affect employees was a major theme of the meeting; indeed, specific training to the needs of employees with mental health issues was promoted as something which would be beneficial, so this is an opportunity for employers/managers – as general "management" of personnel was deemed not to be adequate in terms of knowing how best to navigate the meetings, agreements, timings and deadlines involved in keeping people mentally well at work.

- Those at the meeting agreed that example should be taken from the Scottish Mental Health system, early intervention and return-to-work best practice, the Canadian system and other initiatives at EU level.

- Critical incidents, as a source of stress should be facilitated into bespoke risk assessment control measures, targeting specific work/industry types – i.e. emergency personnel etc.

- Some system of having free mental aid should be considered for the short term control or rehabilitation of those with mental health problems. It was highlighted that there is no one devoted rehabilitation system for people who are short term out of work due to mental health issues.

- Some good practice in the public and private sector should be highlighted and shared.

Generally agreed THREATS

- As societies become increasingly violent, so do workplaces and so violence is an increasing risk at work.

- Working time alterations and increased hours/shift work patterns can be a threat to mental health.

- Conflict and combative relationships are associated with increased pressure in times of recession and this can have a negative effect on mental health at work.

- Re-structuring, job insecurity and decreased and insecure salary expectations, all associated with recession, are threats to mental health and well being.

APPENDIX 1
List of Ireland's Participant Organisations

Bausch and Lomb
http://www.bausch.com/

An Garda Síochána
http://www.garda.ie/

Irish Business and Employer's Confederation (IBEC)
http://www.ibec.ie/

Irish Congress of trade Unions (ICTU)
http://www.ictu.ie/

Irish Defence Forces
http://www.military.ie/

ESB
http://www.esb.ie/

National Disability Authority
http://www.nda.ie/

Afresh
http://www.afresh.ie/

WRC Research
http://www.wrc-research.ie/

Shine Online
http://www.shineonline.ie/

AHR Services
http://www.ahr.ie/

Mental Health Commission
http://www.mhcirl.ie/

Equality Authority
http://www.equality.ie/

Advokat
http://www.advokat.ie/

Legal Aid Board
http://www.legalaidboard.ie/

Economic and Social Research Institute
http://www.esri.ie/

Local Government Management Agency
http://www.lgcsb.ie/

Labour Relations Commission
http://www.lrc.ie/

National Learning Network
http://www.nln.ie/

Dept. of Social Protection
http://www.welfare.ie/

Rehabilitation and Employment Consultants

Dept. of Defence
http://www.defence.ie/

Irish Rail
http://www.irishrail.ie/

University of Limerick
http://www.ul.ie/

MALTA

Joint Action on Mental Health and Well-being:
Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

- Ray Xerri

National Report: SWOT-analysis Malta

Preamble

Respondents tend to agree on what the issues are at the workplace and the way forward to address mental health problems at the workplace. Such consensus is understandable given our geographical size and highly charged political environment.

1. Level of agreement & disagreement concerning most relevant needs for improvement / the perceived challenges

- All respondents agree that the main focus to improve workers' mental well-being is effective and sustainable health education on mental health issues and identification/addressing of stressors at the workplace. Such training should be owned by employers and they themselves should be trained on relevant mental health issues.

- The main challenge is that mental health promotion/prevention is not financially feasible if employers are to incur the cost, given that our industry is mostly SMEs. Another challenge identified is the relative lack of resources at national, enterprise and social partner level.

2. Level of agreement & disagreement concerning the most efficient / effective practices

a. Awareness/understanding [stigma]

- Most respondents opined that all stakeholders are aware of stress related work practices; however the lack of meaningful participation by the social partners to address this issue is a problem.

- Workers with mental health problems are stigmatised; some opined that increasing awareness on such issues can increase stigmatisation and, given current economic conditions, may lead employers to retain the fittest amongst the workers.

- Others opined that as a result of stigma, employees with mental health problems are reluctant to have management and co-workers know about their condition.

b. Legislative framework & soft law [standards, social partner agreements, guidelines]

- Enacting an effective regulatory framework is a must. One respondent opined that the failure of the EC to publish the OHS strategy document for 2013 – 2020 is a threat to the formulation & implantation of any regulatory framework.

- Given that our economic sectors are highly trade unionised, this may facilitate the enforcement of any standards or guidelines, once formulated and agreed to by all social partners.

- The further implementation of family friendly measures that enable better work-life balance can reduce mental health issues. However, some organisations in the private sector do not offer the current full package of family friendly measures due to the financial cost incurred or because of the small number of employees employed, work processes may be seriously affected.

c. Business case [in relation to various stakeholders]

- Most respondents opined that workplace mental health is cost effective, though most said that this is a financial burden on the private sector making such provision not financially viable. Others opined that, given the financial return, social partners should be encouraged to implement effective strategies to reduce work related mental health issues by using their own resources.

- Some respondents opined that there is lack of awareness on the real magnitude of mental health issues at the workplace both in terms of their economic and social impact. Unless such awareness is raised, the problem can not be effectively addressed.

d. Need for dissemination of good practices in enterprises

- Although health promotion material is readily available, there is no strategy to implement mental health promotion/prevention at the workplace. Strategy should be owned by all social partners.

- Some services are available, financed mostly by the public sector such as counselling. Most respondents opined that employers and employees are unaware of such services indicating poor communication channels.

e. Mental health care system [link between internal needs and external providers]

- There is awareness in most stakeholders that stress is a priority at the workplace. However, few are aware of the services provided.

- There is a need for the health department to formulate a stately on mental health promotion/prevention in synergy with other providers like the NGOs.

- Access to services should be facilitated, equally accessible and provided at appropriate time to encourage uptake.

- Current service provision rely more on individual early detection of work related stress without much emphasis being placed on identifying causes within the enterprise. This calls for a more proactive approach by the OHS Authority to identify such causes and prevent work related stress. One respondent suggested that the OHS Authority should include a "mental health team" to address these issues.

- The lack of outreach therapeutic services is considered by some respondents as a problem.

f. Implementation of OSH standards

- The OHS Authority should focus more on mental health issues at the workplace. However, paradoxically, the request by the unions to empower the Authority to tackle work related stress may cause a backlash from employers and hence reduce their potential involvement.

g. Intersectoral cooperation [health & labour] at government & social security level

- This was not identified as an issue, probably because the OHS Authority pertains to the health department.

- Some respondents opined that, given the duration of mental health illness, sick leave should be extended in such instances. However another said that such provision may not be acceptable to employers who fear that the same provision will be requested from workers suffering from physical conditions.

h. Knowledge development

- The need for appropriate training on mental health issues was a common reply amongst all respondents. Training must encompass and tailored to all levels of an organisation from top management to employees. It is imperative that management owns such initiatives. Need for training to all management levels on mental health issues.

- Some respondents suggested that HR departments within organisations should be reformed through appropriate training that focus not merely on administrative matters but also on individual needs and requirements of employees including their mental health needs.

Mental Health Services

- **Organisation and functioning of mental health systems**
  The mental health sector includes both inpatient and community services, forming an integral part of the national health system. One management structure is responsible for all psychiatric services so as to ensure a seamless and consistent service. All services are provided by multidisciplinary teams.

- **Inpatient services**
  Inpatient facilities are mainly located in the psychiatric hospital (Mount Carmel Hospital) and a small unit on the sister island of Gozo. The total number of beds is 581 which includes psycho-geriatrics. There is a 15 bed short stay psychiatric unit in the general hospital. Inpatient services include both general psychiatry and specialised services such as child and adolescence, rehabilitation, dual diagnosis, old age, learning disability and forensic psychiatry. Liaison psychiatry is also provided in the general hospital and joint clinics such as Neuropsychiatry and Perinatal Psychiatric clinics are also provided.

- **Outpatient services**
  Outpatient facilities are provided in the main general hospital and in the various primary healthcare centres. There are also a number of day centres around the island offering psychological, interpersonal and practical living skills group work. Outreach teams support individuals living in the community with severe and enduring mental

illness, who are at higher risk of admission to hospital. A number of hostels and community homes are available that provide safe and secure housing for individuals who have experienced long term in-patient care and need support to live in the community. The Crisis Intervention Team operates on a 24/7 basis from the Casualty Department of the general hospital. The community mental health services also serve the wider community by increasing mental health awareness through the provision of information and education, to aid the cultivation of healthier environments within families, schools and the workplace.

- **Other Services**
  The Malta Richmond Foundation, a non-governmental organisation (NGO), provides a number of services such as inpatient and outpatient rehabilitation schemes, sheltered employment and outreach services.
  Mental health prevention and promotion is mainly provided by NGOs. The Health Promotion Department within the Ministry of Health lacks the human resources to provide such services.
  Psychiatric services are also available in the private sector.

- **Access and usage:**
  Given Malta's geographical size, there is no evidence of inequality of access. Outpatient medication is provided free of charge on a means test or for those suffering from a chronic condition listed under the Social Security Act (eg schizophrenia).

- **Variation and gaps:**
  The main gaps in mental health services are:
  The provision of mental health prevention and promotion activities which are limited within the public sector
  The lack of collaboration between health and social care sectors which continue to operate in silos. No merger is anticipated. This is also the case with NGOs which has resulted in duplication of services provided to the same client group.

- **Financing:**
  The health sector is financed through general taxation. Circa 7 % (22 million euro) of the total government health expenditure is allocated to mental health services, mainly the hospital sector. Despite the economic crisis, the level of expenditure in the health, social and educational sector has increased over the years. The financial statements indicate that the expenditure in the mental sector increased by 15.25 % from 2009 to 2010. It is not envisaged that finances will be reduced; in fact government is committed to increasing the annual financial resources to further expand the community services on an incremental basis. However, the lack of financial resources for prevention and promotion in the mental sector needs to be addressed.

NETHERLANDS

Joint Action on Mental Health and Well-being:
Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

- Irene Houtman
- Rob Gründemann

National Report:
SWOT-analysis Netherlands

The aim of this project & work package is to develop a European action plan on mental health at work. A major and essential ingredient for this is the involvement of the relevant stakeholders and sharing experiences among them on the national and member state level. The Dutch Ministries of Health and Social Affairs and Employment have decided to participate in this "joint action on the promotion of mental health and well-being" with a specific focus on the work package directed at establishing a framework for action to promote taking action on mental health and well-being at workplaces at national level as well.

Key figures from the Netherlands are:

1. The changing quality of work, with:

a. particularly high increases in job insecurity, and increases in temporary contracts (19 % in 2012), and

b. the Netherlands being the service sector country in Europe with violence and harassment as important risks, together with

c. an increase in technology, driving computer use, telework, and all kinds of devices which make work more and more independent of place and time. The Netherlands scores high on these IT-developments.
These developments are related to high work life balance issues .

2. The costs are high. For the Netherlands these have been calculated to be 2,7 billion Euro a year. In addition work-related stress is most often mentioned as the cause of long term (> 3 months) absence. About 40 % of the new entrants into the disability system (WGA part of WIA) are diagnosed to have mental health problems.

There are some highly relevant and recent initiatives to mention for the Netherlands:

• A national action programme by the Ministry of Social Affairs and Employment on psychosocial risk management. It will be launched in April 2014 and will support psychosocial risk management for four years.

• The Ministry of Health also has a national programme on depression where "Employees" are a target group. This programme also starts in 2014.

• Additionally, there will be an advice in 2014 from the Social and Economic Council on the future of the occupational health care, including mental health at work.

This project used SWOT-analyses as a first step towards action. The results of these SWOT-analyses as found in the Netherlands have been discussed with the stakeholders. This resulted in two main areas for future action: (1) the implementation of knowledge we already have (and which are already translated in tools of diagnosis as well as management), and (2) the issue of financing, relating to issues of 'the polluter should pay, which is not the case now. This latter issue is also relating to developing financial tools to make employers and professionals use the evidence (or best practice) based interventions and make occupational health and public health professionals work together and really collaborate.

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[15] High use of IT at work is associated with high work-life imbalance or interference. However, in general work-life interference is associated with long working hours as well. Within a European perspective this aspect may have a low impact when considering the average Dutch worker. This is true particularly for Dutch women, since many traditionally work part time, thereby lowering the average amount of working hours for the Dutch work force relative to that of the average EU workforce.

Introduction

A European Joint Action is initiated which aims to contribute to the promotion of mental health and well-being, the prevention of mental disorders and the improvement of care and social inclusion of people with mental disorders in Europe. This objective will be attained by establishing a process for structured collaborative work on mental health and well-being involving Member States, stakeholders in health and other relevant sectors, and international organisations, in particular the WHO and the OECD. This Joint Action should lead to the development of a common endorsed framework for action addressing issues related to a) promotion of mental health at the workplaces and schools; b) promoting action against depression and suicide; c) developing community mental health care; and (d) promoting the integration of mental health in all policies.

The Dutch Ministries of Health and Social Affairs and Employment have decided to participate in this "Joint action on the promotion of mental health and well-being" (MH-WB, contract 20122202) with a specific focus on the work package directed at establishing a framework for action to promote mental health and well-being at workplaces (WP6).

Three stakeholder groups have been mentioned in the project proposal as central to the project:

1. The social partners (employer and employee representatives) at (inter)national as well as sectoral level. For the Netherlands this means representatives from VNO-NCW, AWVN as national employer representatives. The FNV, CNV and MHP represent the employee representatives. Additionally representatives from the sectors of "education" and of "health care and social work" were approached since mental health is a sensitive but specific risk in these sectors (VOION and Actiz; respectively).

2. Public and private stakeholders in the area of health and social security.

a. In the Netherlands these are the Social Insurance Administration (UWV), the Health Care Insurance Board (CVZ) as well as sector organisations like the Dutch Association of Insurers (VvV), and some large private insurance organisations such as Achmea.

b. In addition, relevant professional groups are involved as stakeholders as well, such as the occupational health physicians (NvAB), the work and health psychologists (NIP), the General Practitioners (NHG, LHV), the Dutch Association of Mental Health and Addiction Care (GGZ Nederland), the national organisation which stimulates a healthy return to work and sustainable employment (OVAL), and the national organisation of first line care (LVG).

c. Additionally, also some experts from universities and knowledge centers [16] (University of Groningen, Utrecht and Nijmegen, as well as RIVM, Trimbos, NCvB; Tranzo) were included as stakeholders.

3. The government. In the Netherlands, the national stakeholders involved in this project are representatives of the Ministries of Health and of Social Affairs and Employment, including the Labor Inspectorate.

The improvement of mental health at the workplace can be done by (1) supporting organisations in preventing mental health risks, (2) reducing mental ill-health or even by (3) proactively stimulating mental health, and (4) stimulating return to work in case absence is due to mental health problems.

In this report we will first find some answers as to the urgency of this project: why is mental health in the workplace an issue that needs attention in the Netherlands, and where is the Dutch situation specific as compared to the EU or specific as indicated by its own trend information. Next we will present the methodology used to get to the aim of the project: come up with an action plan on mental health at the workplace. In order to arrive at a joint action, either at the national or EU-level, is quite complex. The first step to be taken is doing a SWOT analyses (SWOT = identification of Strengths, Weaknesses, Opportunities and Threats). Integrating SWOTS from the relevant stakeholders and providing a national overview is central to this report. In a final paragraph a reflection on these stakeholder SWOT-analyses will be provided.

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[16] TNO is also one of the relevant knowledge centers. Since TNO is the research institute that performs this project, it is not consulted as knowledge center here, but the TNO knowledge on the topic of mental health is reflected in this report through the literature used and the interpretation of the results.

Why is mental health in the workplace an issue that needs attention in the Netherlands?

The world of work is changing through globalization, a shift towards more service work and technological changes which result in a "knowledge society" and "new ways of work", leading to new demands, new risks and new challenges for the workforce, now and in the years to come. In addition, the workforce itself is changing also, amongst others we see a "greying" workforce in the Netherlands. These changes may affect the mental health of workers and may need changes in policies directed at health as well as at social affairs and employment.

In this paragraph we will discuss the impact of these changes in the "world of work" on the quality of work', on the costs for society, and on the stakeholders as addressed in the Joint Action. We will restrict this paragraph mainly to data from the Netherlands and conclude with specific reference to the Netherlands. Since the Netherlands has been and still is quite active in launching initiatives which aim at the improvement of "quality of work" and mental health, and particularly on the topic of psychosocial risk management, we additionally include information on large scale national initiatives that have been taken since the introduction of the Working Conditions Act until present.

The quality of work is changing

The changing workplace, with globalization and migration of workers, increased reliance on technology, and pressures from international economics, may add pressures that are detrimental to the mental health of the workforce (OECD, 2012). In general terms, there are three drivers for the changing work place.

The first is ongoing *globalization*, a term which refers to the integration of national and regional economies. It has led to increased competition between commercial organisations, to a shift in the type of business operations in which organisations are engaged, and to extensive outsourcing of activities, primarily to the low-wage countries. Globalization has led to a *flexibilization* of the work process, with more part-time employment, temporary employment and independent contracting of staff (as reported by Kawachi, 2008; EU-OSHA, 2007). Houtman and Van den Bossche (2010) confirm that based on Eurostat data, there has indeed been a significant increase in the number of employees holding temporary contracts within the EU. In 1990, the figure for the European average was 10 % which by 2012 had risen to 14 % of the total workforce. In the Netherlands this increase has been much stronger: from 8 % in 1990 to 19 % in 2012 (Figure 1).

Dutch research has shown that workers with a temporary contract have an increased risk of losing their job. However, the recent recession resulted in an increased job loss of workers with both a temporary as well as a permanent contract (e.g. Dekker & Aussems, 2013). Research also showed that, when temporary workers have developed health problems and became absent, particularly when they have mental health problems, on average about one in ten employers will invest in their return to work, whereas this is no issue for employees with a permanent contract (Houtman et al. 2013).

Restructuring itself has been on the increase in the Netherlands due to the economic crisis since the end of 2008. This development results in a lot of insecurity in many organisations and in a lot of people becoming unemployed. The Na-
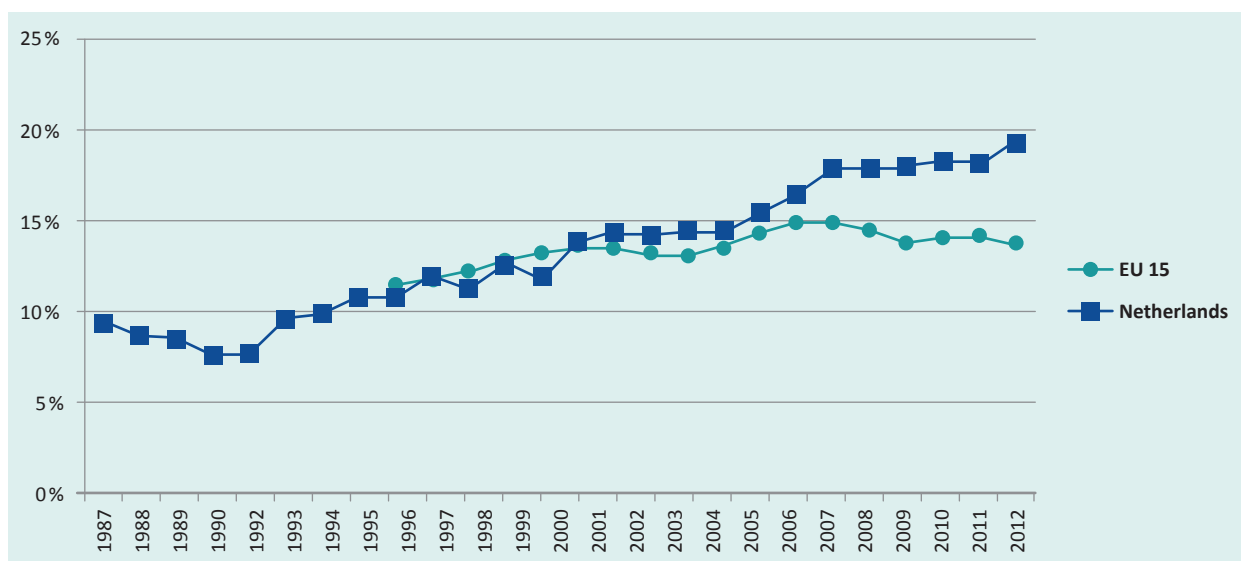

Figure 1 The development of temporary contracts in the Netherlands and in the EU
Source: Eurostat

tional Working Conditions Survey (NWCS) confirms the trend of an increase in self-reported job insecurity among Dutch employees since 2007 (Hooftman et al. 2013).

However, restructuring is not only to be considered a serious threat to individual health for those who lose their job (the "direct victims") but also to their immediate environment. Evidence during the past two decades also showcases the impact of restructuring on the so-called "survivors" as concerns (mental) health, productivity, and organisational commitment (e.g. Kieselbach e.a., 2009).

Changes in psychosocial risks which may be indicative of intensification, however, are not seen in the national nor the European EWCS data for the Netherlands (Hooftman et al. 2013). Psychological demands have been quite stable since about 2000. In 2000 these demands were quite high as related to other EU-member states, but in 2005 the Netherlands have become "average" based on data from the European Working Conditions Survey (EWCS; Houtman & Van den Bossche, 2010). Additionally, workers in the Netherlands experience a relatively high level of autonomy, varied work and learning opportunities. High psychological demands, as well as low levels of autonomy, monotonous work and lack of learning opportunities are generally associated with mental health problems and low productivity (e.g. EU-OSHA, 2007; Houtman & Van den Bossche; 2010; Netterstrom et al. 2008).

The second key development is the *tertiarization* of the labour market, manifested in increased demand for staff in the services sector and reduced employment opportunity in industry and agriculture. In fact, this development became apparent in the early years of the twentieth century but in recent decades may well have been reinforced by globalization, since the outsourcing of manual labour to low-wage countries left only, or predominantly, the service economy. This labour market shift can be seen at both the national and the European level (EU-OSHA, 2007; Peña-Casas & Pochet, 2009). This trend has been quite prominent in the Netherlands as well: the (growing) share of labour market by sector shows that the service sector in the Netherlands is quite high given the EU on average (see figure 2). This is consistent with a rather stable, but as compared to other EU-countries, relatively high level of violence and harassment at work as experienced by the Dutch worker (Houtman & Van den Bossche, 2010; Van den Bossche et al. 2013).
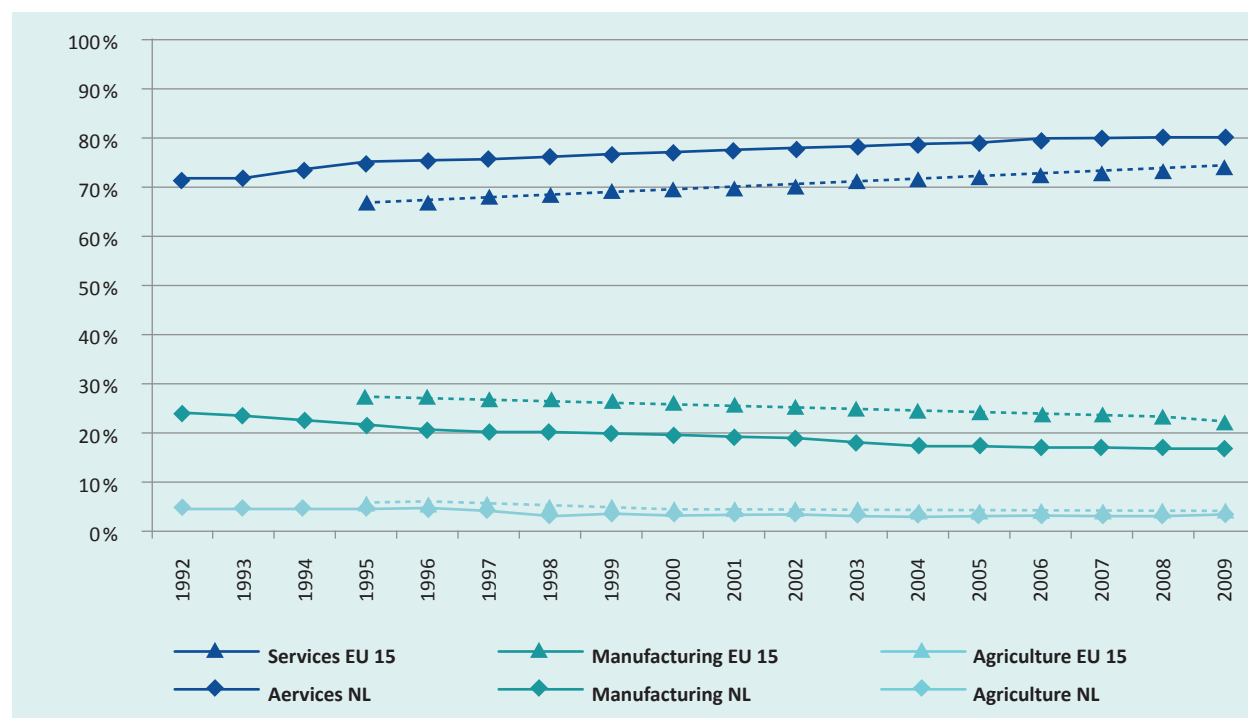

Figure 2 Trends in share of labour market by sector for the EU on average and for the Netherlands Source: Eurostat

The third key development relates to technological advancement and the emergence of the computer, the internet and other digital equipment, which has led to many changes and innovations in work processes. Many forms of manual work have become obsolete and staff must now offer different skills and qualifications (Joling & Kraan, 2008). This will be associated with the fact that more and more people will be working with information and innovation of the work(place) and the work products have received more and more attention. In the Netherlands the availability of a computer at home as well as at work has been increasing and is exceeding the EU average by far (Eurofound, 2012).

We have seen the introduction of "new work", a term which amongst others refers to telework, i.e. working from home or a location other than the traditional office. There are many work activities which can now be conducted regardless of time or location: while travelling on the train, at home and – if we are to believe the television commercials – on some distant exotic beach or in the middle of a tropical rainforest. This development is considered to result in many new challenges at work, but it also results in blurring the border between "working" and "private life". Work can take place outside the traditional working hours as well as at home or when travelling. This is a new development and one which can impinge on the need for rest and recuperation, or interfere with personal commitments. This work-home interference is found to result in increased burnout and mental health complaints (e.g. Demerouti et al. 2004, 2007; Montgomery et al. 2003).

Studying the effect of the "new way of working" in the service sector, Van den Bossche et al. (2013) concluded that the nature (and perhaps quality) of client contact is changing, leading to higher perceived violence risks for those workers who combine service work and computer work.

Studying the effect of the "new way of working" in the service sector, Van den Bossche et al. (2013) concluded that the nature (and perhaps quality) of client contact is changing, leading to higher perceived violence risks for those workers who combine service work and computer work.

Changing workforce

The workforce itself is changing also, it is ageing. This has to do with the fact that people grow older, but also fewer younger people enter the labour market. The increase in the average age in the Netherlands as compared to some other European countries is quite average (still[17]) . However, since the labour participation of older workers is less than that of younger workers, the ratio of retired elderly to the active working population induces pressure on public finances (Geuskens et al. 2012). This development already resulted in a rise in the official retirement age in several European countries. In the Netherlands this official retirement age has increased from 65 to 67.

In the Netherlands, the percentage of employees who say they are willing to work until the (former) age of retirement and who say they will be able to do so has been increasing since 2005 (when it was measured for the first time; Geuskens et al. 2012). However, a lot of people may not be able to reach the official retirement age. We see that the average retirement age is 63.5 years now and has been increasing since 2007 (CBS, 2013[18]). Geuskens et al. (2012) show that psychosocial factors at work such as autonomy or decision latitude and good social relations at work considerably facilitate the participation on the labour market of older workers.

Costs of mental health

There is strong evidence to indicate an association between exposure to psychosocial risks and work related health complaints. Psychosocial risks in the workplace have been shown to have a detrimental impact on workers' mental and social health (e.g. Tennant, 2001; Chen e.a., 2005). Recent reviews studying the relations between (psychosocial) factors at work and (major) depression as well as less severe common mental disorders (e.g. Netterstrom et al. 2008; Kuoppala, Laaminpää & Vaino, 2008) conclude that psychosocial risks at the workplace are related to an elevated risk of subsequent depressive symptoms or a major depressive episode, however methodological limitations preclude causal inference.
In addition, there is also evidence showing that (in Dutch and Swedish society) psychosocial factors at work are predictive of job satisfaction, intention to quit, or the ability as well as the willingness to work longer (Geuskens e.a., 2012; Canivet e.a., 2013). The "greying" work force in the years to come will continue to put pressure on the participation in the workforce of older workers. A recent review by Croucher e.a. (2013) showed that companies investing in quality of work show better performance.

The costs of mental ill-health for society are large, reaching 3 – 4,5 % of GDP across a range of selected OECD countries in 2010 (OECD, 2012). For the Netherlands these costs have been calculated at 2.7 billion Euro (De Graaf et al. 2011). Most of these costs do not occur within the health sector. Mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work (OECD, 2012). Matrix (2013) recently estimated (for a certain scope and conditional to numerous assumptions) that the total costs of work-related depression in the EU27 are nearly € 620 billion per year. The major impact is suffered by the employers due to absenteeism and presenteeism (44 %), followed by the economy in terms of lost output (39 %), the health care systems due to treatment costs (10 %), and the social welfare systems due to disability benefit payments (€ 40 billion).

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[17] http://www.eurofound.europa.eu/resourcepacks/activeageing.htm
[18] http://www.cbs.nl/nl-NL/menu/themas/arbeid-sociale-zekerheid/publicaties/artikelen/
archief/2013/2013-3769-wm.htm

TOP TEN OF DISEASE	LOST LIFE YEARS % OF SELECTION	SICKYEAR-EQUIVALENTS % OD SELECTION	DALY'S % OF SELECTION	DALY'S % OF TOTAL
Coronary heart disease	12,7	9,5	10,6	6,9
Stroke	8,7	6,3	7,1	4,6
Anxiety	0,0	10,3	6,8	4,4
Depression	0,0	8,6	5,7	3,7
Diabetes mellitus	3,4	6,7	5,6	3,6
Lung cancer	14,7	0,5	5,3	3,5
COPD	5,9	4,4	4,9	3,2
Artrosis	0,1	6,3	4,2	2,7
Accident (private)	3,1	3,9	3,6	2,3
Dementia	4,4	2,9	3,4	2,2

Table 1 Top ten of disease[20] with the largest loss of DALY's in the Netherlands in 2007 (percentage of 56 selected diseases and estimated percentage of all diseases)

Another way to look at costs of (mental) health is considering the "burden of disease". This burden of disease is expressed as DALY's (Disability-Adjusted Life-Years'). The number of DALY's is the number of healthy years lost in a population because of disease. With the help of DALY's diseases can be easily compared. This approach helps policy makers in the area of public health to prioritize. In the Netherlands, almost 650,000 people in the age group of 18 – 65 have a mental health disorder. About 550,300 of these were diagnosed to have a depression. In the list of diseases from the Global Burden of Disease project depression is rated fourth (Murray et al. 2012). This is because depression has a high negative impact on individual functioning, relatively often occurs at young age and often is chronic in nature. The total burden of disease because of depression calculated for the Netherlands was 168,600 DALY.[19]

A trend analysis of mental health in the Netherlands from 1996 to 2009 showed that the 12-month prevalence of anxiety and substance abuse disorder did not change. The prevalence of mood disorder which mainly consists of depression decreased slightly, but this trend lost significance after correction for demographic characteristics (De Graaf et al. 2012). Despite this lack of change in the mental health status of the Dutch population, mental health problems are the main cause for long term sickness absence and 43 % of reported new cases in the new Dutch disability benefit system are diagnosed to be related to mental health problems (Hooftman et al. 2012).

Initiatives from the past and present

In this joint action, an action programme is aimed for as well as collaboration and common endorsement by and where possible commitment of stakeholders, both at national and EU-level. In the Netherlands already many initiatives have been taken since the (gradual) implementation of Working Conditions Act (1983 – 1990), some initiatives were stimulated by the ministries, but others were stimulated by other stakeholders. Several of these initiatives were:

- The development of WEBA (WElzijn Bij de Arbeid); a tool initially designed to help the Labour Inspectorate to identify psychosocial risks and support and advise organisations to improve their "mental health" (1990 and onwards);

- Handbook of Work-related Stress and related good practices. These practices have extensively been described, but apparently professionals/researchers & organisations appear to forget, not resulting in a long-term dissemination effect;

- Trend report production and regular monitoring activities including psychosocial risks and mental health indicators have been intensified into a yearly monitor since 1997;

- The research programme on mental fatigue (NWO-Priority Program) resulted in a lot of high quality knowledge and data collection at universities in the Netherlands and PhDs from about 1998 – 2010;

- Social security programme on "Prevention Occupational Health Service" (SIG-programme);

[19] http://www.nationaalkompas.nl/gezondheid-en-ziekte/ziekten-en-aandoeningen/
psychische-stoornissen/depressie/omvang/

[20] http://www.nationaalkompas.nl/gezondheid-en-ziekte/sterfte-levensverwachting-en-daly-s/
ziektelast-in-daly-s/wat-is-de-ziektelast-in-nederland/

- Guidelines have been developed by the Occupational health physicians as well as the first-line Psychologists specifically directed at "return to work" of workers who have become absent or disabled with mental health problems (NvAB, 2007; NIP/LVE, 2005). The Ministry of Social Affairs and Employment installed a Committee on "mental disability" at the end of the previous decade, which initiated amongst others these specific guidelines (CPA, 2001);

- Work and health covenants that stimulated a sector-wide approach with a particular focus on psychosocial risk management (1999–2002) and stimulating return to work, amongst others after having developed mental health problems (2002–2007).

Ongoing initiatives are:

- Action plan on "healthy business". The Ministry of Social Affairs and Employment gives grants to support employers, particularly SMEs for managing heavy (physical and mental) workload. This action plan is specifically targets building and construction, transportation and (health) care;

- The Minister on Social Affairs and Employment recently (december 2013) presented an "Action plan on psychosocial risk management". The initiation of this plan consists of a targeted approach for psychosocial risk management for four years (1 million Euro a year). In spring 2014 (April) a more specified action plan was formulated;

- National Program on Prevention (NPP): a framework programme was initiated by the Ministry of Health which targets – amongst other risk groups – also occupational sectors at risk (e.g. health care, education);

- The Ministry of Health directs itself specifically at depression. Amongst other target groups "employees" at risk should be able to use a Depression Management programme (NPP);

- Within the context of the "management of chronic illnesses", "work" has become part of the "care standards"[21] in which work is considered to have a "healing role";

- Recent relevant developments also include the proposal of CVZ to suggest that work-related mental health problems should not – in their opinion – be included in the national health insurance;

- The Minister of Social Affairs and Employment, Asscher, asked the Social and Economic Council of the Netherlands (SER; which is a national advisory and consultative body of employers' representatives, union representatives and independent experts[22]), to advise on the future (scenarios) on occupational health care.

Methods

The joint mental health at work initiative aims to collect information from the national stakeholders. Its aim is to integrate it into a larger EU-view on strengths, weaknesses, opportunities and threats (SWOT) which should feed into the identification of priorities of potential activities for mental health policies in Europe. For the Netherlands it is clearly also results that should feed into opportunities for improving mental health in the broad sense and be translated into a plan of actions. The method used for this is initially the SWOT analysis. Each national stakeholder is asked to identify strengths, weaknesses, opportunities and threats in relation to psychosocial risks and mental health.

As for the Netherlands, the SWOT analyses were performed for four areas:

- (Proactive) improvement of mental health at the workplace,

- psychosocial risk management at work,

- reduction of mental health complaints in workers, and

- stimulating return to work in employees with mental health problems.

In the Netherlands, the stakeholders were first invited to join a kick off meeting on April 24, 2013. The aim of this first meeting was to make the stakeholders feel the urgency and stimulate commitment for an action plan on mental health at work. In addition, the SWOT was introduced as a method that would facilitate the identification of potentially effective as well as feasible actions. In addition, a (part of a) SWOT analysis was performed with the group of stakeholders present. After this kick off meeting a SWOT questionnaire was sent to all stakeholders, and they were asked to discuss the SWOT on the four mental health areas (see above) within their organisation, to complete the questionnaire and to send it back at TNO.

Overall analyses of the SWOT stakeholder responses were performed. Feedback to the stakeholders of the SWOT-results was delivered in a second meeting on October 2nd, 2013. At this meeting, the first interpretation of the data was discussed and directions for action were prioritized.

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[21] http://www.cvz.nl/kwaliteit/kwaliteitsbibliotheek/zorgstandaarden
[22] http://www.ser.nl/en/about_the_ser/statutory_trade_organisation.aspx

Results

Stakeholder response

An overview of stakeholder responses is shown in table 2.

STAKEHOLDER GROUP	ASKED TO COMPLETE SWOT	RETURNED THE SWOT
Employer representatives (national and sectors health care, education)	4	3
Employee representatives	3	2
Care providers	9	6
Insurances (public (UWV) + private)	7	3
Knowledge institutes	8	6
Ministries (incl. Inspectorate)	3	3
Total	34	23 (68%)

More than two thirds of the stakeholders completed the SWOT analyses and returned them (net response is 68%). Not all respondents covered all four areas, since respondents did not consider themselves "expert" enough on the area(s) not completed, and/or their focus as organisation was only restricted to one or two of the four areas. A lot of overlap was reported on the strengths, weaknesses, opportunities and threats across the four areas, as well as overlap between SWOT results from the different stakeholders.

Strengths

The main strengths from the SWOT analyses are:

- The knowledge in the Netherlands on mental health and its determinants (monitor information, knowledge on the topic as well as on interventions):
  - Developments in "mental health"
  - In risks
  - In risk groups
- Infrastructure
  - Care infrastructure on "mental health"
  - National collaboration & consultation to the government in topics like psychosocial risks and mental health (The Labour Foundation (StvdA) and the Social and Economic Council (SER))
  - Legislation on working conditions and social security
  - Strong knowledge (and ICT)-infrastructure
- National collaboration
  - Work & health catalogues (sector-wide documentation on legal obligations on working conditions, diagnostic tools, intervention tools, good practices. This documentation is often made available by internet)
  - Collective agreements
  - Sectoral consultation & collaboration
- Commitment of all stakeholders

Some issues were somewhat more specific for either the area of mental health or for a specific stakeholder. In general, the knowledge and tools on how to (proactively) promote mental health was considered less well-developed in general than on the other three "mental health" areas. Fewer tools were available and little or no good practices. However, the representative from the sector of "Education" indicated that there was a lot of knowledge within "his" sector on mental health and "mental capital". In general the attention of mainly the human resource management for "mental health in a broad sense" is considered increasing. Employee representatives indicated that the awareness of mental health was mainly increasing among the highly-educated and not so much among the lower educated.

The Netherlands are unique in that they have a "specialist" education on the topic of "work and health" ("arbeids-deskundige"). They are particularly well equipped to help organisations manage their mental health risks and mental capital issues. Several stakeholders urged the importance of linking particularly the issue of the proactive promotion of mental health and psychosocial risk management to upcoming topics of sustainable employability, social innovation and corporate social responsibility. These are important developments relevant in respect of the need for skilled personnel now and in the near future that is able to develop with technological developments to fit the new jobs of the future.

On the other hand, the Labour Inspectorate is also in a state of "high awareness" for specific risk sectors and organisations at high risk of mental ill-health, e.g. health care and social work as well as education. The capacity of the Labour Inspectorate is restricted, so prioritization to organisations at risk is imperative for them. The (evidence based) e-health programmes on mental (ill-) health management are increasingly popular. They are quite cheap and provide a low threshold resulting in easy access for many people.

Weaknesses

The main general weaknesses from the SWOT analyses are:

- Available knowledge is not used enough/not well-implemented

  - Employers do not always know what is available/knowledge does not reach target groups,

  - Topic is surrounded by a "sensitive"/taboo atmosphere, both for employers and employees

- Infrastructure is complex, a holistic vision on mental health is lacking and "work" often does not get enough attention (too much attention the professionals choose for curation/the medical model and too little for prevention)

- Field is strongly segmented

- Securing (successful) programmes/activities gets too little attention

- Government does NOT choose: no compelling measures to activate/stimulate companies

- When employers do NOTHING, society/insurances pay(s) → prevention and curation have different financial arrangements and different actors (public health – versus – "commercial" occupational health) → this results in a situation where the "polluter does not pay".

Some specific weaknesses were reported as well. Regarding proactively promoting "mental health" the remark was made that "there is no legislation" and (as also indicated when considering the strengths) the rise in awareness is mainly restricted to the highly-educated.

The topics of positive mental health (engagement etc.) are not very concrete, and psychosocial risks at work as cause of mental health problems are not very "objective". This often leads to discussions about who is responsible for its management between the employer and employee and their representatives. The often-heard "employer's opinion" is that psychosocial risks belong/are inherent to the job. The Labour Inspectorate also experiences difficulties in enforcing psychosocial risk management because of the fact these risks are not so easily made objective.

The "return on investment" and positive effects of proactively improving mental health as well as of psychosocial risk management at the organisational level are difficult to (objectively) measure. In general, the effectiveness of interventions directed at the individual with mental health problems or in terms of the reduction of the absence period is often much easier to measure and quantify.

In particular, interventions directed at the reduction of mental health complaints as well as of return to work are better made concrete but they are often performed within the context of the medical model. Research directed at improving return to work only recently showed the independence of the level of mental health complaints and the ability to return to work when one dropped out due to mental health complaints.

Particularly the knowledge gained on stimulating return to work is not always implemented because of practical reasons: sometimes the employer cannot offer temporary part-time work or less demanding work. This is particularly problematic for small enterprises. On the other hand, sectoral or regional networks of organisations – even of the small ones – can achieve much more in this respect than when they want to tackle problems like mental health on their own.

A weakness which was also considered specific for the individually directed interventions on mental health problems and return to work processes is the fact that there are different financing systems for public and (the private) occupational health. This is also a major cause of relatively little collaboration between the public health and occupational health professionals.

Opportunities

The general opportunities that are identified with the SWOT are:

- Initiatives for "mental health@work" must be linked to broader, integrated programmes (e.g. sustainable employ-ability, social innovation)

- Major attention for psychosocial risk management from the Ministry (action plan Minister of Social Affairs and Employment (Asscher); see also ongoing initiatives)

- Make knowledge on interventions (target group specific) publicly available

- Use ICT/technology: for providing knowledge as well as tools. E-health has a low threshold for users, anonymous, relatively cheap, good spread

- Also attention to "bad practices" (doing nothing also results in costs)

- Make topics like psychosocial risk management or sustainable employment "sexy" using taxes

- Do something about the different financial circuits of public and (private) occupational health.

We can also identify some specific opportunities for one or two of the four areas we identified on mental health. The proactive promotion of mental health and mental capital is less threatening than managing risks or direct interventions at those with mental health problems or those who are long term absent, since there are no problems yet.

The "business case" model may persuade employers and other stakeholders in primary prevention in those cases where there are no problems yet, or when interventions are complex and difficult (such as at organisational level). Stimulating networks (at sector or regional level) may be beneficial to persuade stakeholders (employers) to act, collaborate and show that interventions pay off. Regional networks may (for other regions) also stimulate return to work, e.g. by providing partial and less-demanding (temporary) opportunities for work.

Threats

Important general threats identified with the SWOT are:

- The economic crisis

- A "tough" environment as a result of the crisis

- There is too little reflection on the consequences of higher pension age and demographic changes

- Not all stakeholders think the "problem" of mental health at the workplace is that urgent

- Withdrawal of the public administration, meaning more of a "participation" society and less of a "care" society

- New risk groups: e.g. caregiver who provides informal care (and is compelled to do that to an increasing extent) and also has to earn a living. The new government policy is to cut health care costs and not take up elderly into care that easily at the cost of many elderly for which this division line is not clear

- Separate financing public and occupational health care is difficult to change

- How does one prevent new bounderies when one reconstructs the system

- Influence ICT: too much, non-selective info

- Undirected instruments also reach individuals who do not need them/are not target group. This may cause a risk to them

- (successful) programmes set up

- Not wanting/daring to stand up (sensitive issues).

Here too, there are specific threats identified for the four mental health areas. The crisis will particularly affect the more "difficult" thus "insecure" trajectories, and those areas of intervention where there are no problems yet. Therefore it will hinder much more the proactive promotion of mental health and the psychosocial risk management at the organisational level. Where participation is considered to be an important success factor of organisational level interventions, this is often considered (too) expensive when money (and thus time) is scarce.

The general trend in organisations is that they increasingly work with workers on a temporary contract. Research has shown that employers do not tend to invest much in employees with temporary contract, both in terms of sustainable employability of these employees as well as in a return to work process in case they have become absent.

The separate financial systems for public and occupational health may well result in a shift of managing (mental) health problems in the more expensive 2nd line/specialist health care. The commitment of the public (mental) health care towards an employee who is absent from work is quite low. Treatment is often directed at health management and not at the level of functioning of the worker. The tendency for using protocols helps in administering "structure", but may also result in a lack of "tailoring" in the care or help provided.[23]

Discussion

The SWOT analyses aimed to result in recommendations that could easily be transformed into an action plan. Therefore the SWOT analyses were performed and their results were analyzed and presented to and consequently discussed by the stakeholders. It was clear that in answering the SWOT generally not very many or typical differences were noted between the different stakeholders. Of course those who included their opinions in the SWOT often introduced slightly different issues. One of the typical and explicit issues for the employee representatives was that they are of the opinion that the Labour Inspectorate should have more capacity and should be able to inspect much more companies. They should also sanction those – ideally all – companies that do not comply with the working conditions act, in the sense that good quality of work is maintained, including a good psychosocial working conditions climate. The Labour Inspectorate in the Netherlands is relatively small (see also Scoreboard 2009, DG Employment, 2010) and is forced to really prioritize. Which they do, also on psychosocial risks and mental health.

During the discussions after the presentation of the results it was clear that on many issues a lot of consensus was present regarding the identified strengths, weaknesses, opportunities and threats. During the feedback session a framework for (policy) actions was prepared and presented. The framework for policy actions presented at the meeting was:

- Awareness raising, agenda setting
- (Further) knowledge development
- Implementation of knowledge + business case
- Directing (roles and responsibilities)
- Financing (business case)
- Collaboration/infrastructure
- Legislation & maintenance.

First, the stakeholders were asked whether the list needed further topics. The stakeholders concluded that this list was quite complete, although the labelling of the list (is it a framework for action or is it something else) was an issue to be discussed. The list was nevertheless prioritized in a workshop session after splitting up stakeholders who wanted to discuss on activities directed at (1) psychosocial risk management or proactively promote mental health and mental capital, or (2) the management of mental health problems or stimulating return to work after having dropped out of work with mental health problems. Particularly employers and employee representatives have a specific important role in the first group, whereas , stakeholders like the (occupational and mental health) care providers have a quite significant role in the second group. For some other stakeholders, e.g. insurances and policy makers both types of mental health areas are important.

After discussing priorities for an action programme on mental health using the framework presented, both groups prioritized the implementation of knowledge thus far obtained (e.g. in a business case) as most important as well as the inclusion of the financial issues and different financial systems of public and occupational (mental) health. As for the EU, these kinds of differences have hardly been identified and analysed. Still, the priorities appear to be the same for the different areas of mental health, although the specific activities that result may still differ.

It is felt that discussing these activities more in-depth with several stakeholders individually may help or even be necessary in order to come to a more concrete plan of action on mental health at work. For the Netherlands, the recent action plans from both the Ministry of Health as well as the Ministry of Social Affairs and Employment and their request for advice from the Social and Economic Council on the future of occupational health care, including mental health at work, are extremely important.

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[23] Apart from the SWOT topics, in the questionnaire the stakeholders were also asked which actions they considered necessary for a specific mental health area. As far as stakeholders formulated actions, they will not be reported here. Stakeholders generally tended to suggest activities they themselves have a role in or benefit from.

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SLOVENIA

Joint Action on Mental Health and Well-being: Mental Health at the Workplace

PROMOTION OF MENTAL HEALTH AT THE WORKPLACE

prepared by

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National Report: SWOT-analysis Slovenia

1. Introduction

The project Promoting Health at Workplaces is carried out in the framework of the European project Joint Action on Mental Health and Well-Being (JA MH WB), Grant Agreement Nr. 2012 22 02, which is designed in the context of the developmental strategy of the European Commission, "Together for Health". The entire project combines 30 partners from 21 European countries and is headed by the Project Board with the Advisory Committee. The project is divided into eight work packages. Slovenia is working on several packages, together with other partners. The Ministry of Health is participating in the coordination of joint activities, dissemination and evaluation (work packages 1, 2 and 3) and the Health Insurance Institute of Slovenia is working with various stakeholders on work package 6 – Promotion of Mental Health at Workplaces (JA MH WB – WP 6).

The main purpose of the project Promotion of Mental Health at Workplaces (JA MH WB – WP 6), in collaboration with various stakeholders in the field of health and social care or labour policies is to create a joint action plan for the promotion of mental health at workplaces in the European Union. Altogether, 12 European countries are participating in JA MH WB – WP 6: Austria, Belgium, Finland, France, Croatia, Iceland, Ireland, Hungary, Malta, the Netherlands and Slovenia. National coordinators have been appointed for all participating countries. The Health Insurance Institute of Slovenia and its representative, Mr. Boris Kramberger, took on the role of national coordinator of the project in Slovenia, on the initiative of the Ministry of Health. At European level, in the substantive and organisational context, project JA MH WB – WP 6 is coordinated by the BKK Dachverband (BKK Federal Association of Company Health Insurance Funds) and its representative, Dr. Gregor Breucker.

In accordance with the pre-defined approach, the national coordinators of the participating countries established a national working group comprised of representatives of government agencies, social and health insurance providers, social partners and various professions related to the field. The objective of the national working groups was to carry out a snapshot of the situation and address the current challenges in the promotion of mental health in the workplace, including presentations of examples of good practice. For this purpose, a common methodological approach (SWOT analysis) was established which enables all national working groups to assess the strengths and weaknesses of the current situation and the opportunities and risks in the field of the promotion of mental health in the workplace in a comparable way, especially with regard to the possibility of implementing various examples of good practice.

2. National SWOT process

2.1. Formation and activities of the national working group

In accordance with the Protocol on Cooperation, within the framework of the JA MH WB – WP 6, a national working group comprised of representative of government agencies, social and health insurance providers, social partners and various professions related to the field was established already in 2012, before the formal start of the project in February 2013. 22 representatives of the following organisations were appointed to the national working group to define the status and development potential in the promotion of mental health in the workplace:

- **governmental bodies:** Vladka Komel (Ministry of Labour, Family , Social Affairs and Equal Opportunities) , Nadja Čobal (Ministry of Health), Agata Zupančič (Ministry of Health), Vesna Kerstin Petric (Ministry of Health),

- **social partners:** Tatjana Čerin (Slovenian Chamber of Commerce), Katarina Železnik Logar (The Chamber of Craft and small business of Slovenia) and Lučka Boehm (Association of Free Trade Unions of Slovenia),

- **professionals in the field of health:** Dušan Nolimal (Institute of Public Health), Maja Zorko (Institute of Public Health), Nuša Konec (Institute of Public Health Celje), Blanka Korez Plesničar (Psychiatric Clinic Ljubljana), Metoda Dodič Fikfak (Clinical Institute of Occupational, Traffic and Sports Medicine), Tanja Urdih Lazar (Clinical Institute of Occupational, Traffic and Sports Medicine), Marija Molan (Clinical Institute of Occupational, Traffic and Sports Medicine), Eva Stergar (Clinical Institute of Occupational, Traffic and Sports Medicine), Marjan Bilban (Faculty of Medicine, University of Ljubljana) and Vojko Strojnik (Faculty of Sport, University of Ljubljana),

- **social insurance providers:** Emilia Pirc Čurić (Pension and Disability Insurance Institute of the Republic of Slovenia), Samo Burnik (Pension and Disability Insurance Institute of the Republic of Slovenia), Vesna Švab (Health Insurance Institute of Slovenia), Nena Bagar Bizjak (Health Insurance Institute of Slovenia) and Boris Kramberger (national coordinator of the project, Health Insurance Institute of Slovenia).

The national working group comprised these people at its first convening on June 2013.

For an in-depth discussion on the state and development challenges in the field of mental health in the workplace to be undertaken by the national working group, a methodology was predefined in the project, namely a SWOT analysis. The SWOT analysis1 is supposed to identify and consider the views and positions on the main strengths and weaknesses of the current situation and opportunities and risks in the future regarding the promotion of mental health in the workplace in Slovenia. The research instrument enables brainstorming on selected issues of the observed problems, which equally considers all the answers of those participating in the analysis. A prerequisite for high-quality results are carefully selected participants who can evaluate problems from different perspectives.

The basis for conducting the SWOT analysis was the standardised SWOT questionnaire[24] that was completed individually by members of the national working group, as well as the consideration and coordination of proposals obtained by the questionnaire at the (2nd) joint SWOT conference of the national working group.[25]

In compliance with the definitions of the promotion of mental health in the workplace, the SWOT questionnaire contained two basic sets of questions:

1. Questions regarding measures to promote health in the workplace in Slovenia

   – *What do you think are the main advantages and disadvantages of current measures implemented in order to protect and promote health in the workplace in Slovenia, especially in relation to mental requirements?*

   – *Looking into the future, what do you think are the main opportunities and risks that will have an impact on protection and promotion in the workplace in Slovenia, especially in relation to mental health requirements?*

   – *Which three recommendations would you suggest to improve the situation in the field of the protection and promotion of mental health in the workplace in Slovenia, especially in relation to mental requirements?*

2. Questions regarding support for employees in Slovenia who are already affected by mental and behavioural disorders

   – *What do you think are the main advantages and disadvantages of current measures implemented to support employees in Slovenia who are already affected by mental and behavioural disorders?*

   – *Looking into the future, what do you think are the main opportunities and risks which will have an impact on support for employees in Slovenia who are already affected by mental and behavioural disorders?*

   – *Which three recommendations would you suggest to improve support for employees in Slovenia who are already affected by mental and behavioural disorders?*

On May 29, 2013, all members of the national working group received the SWOT questionnaire with both sets of questions on the promotion of mental health in the workplace, together with explanatory and methodological materials envisaged in the project. 12 out of 22 members of the national working group returned the individual assessments and proposals in the answers to the questionnaire.

The first meeting of the national working group or the SWOT conference was conducted on June 21, 2013, from 9:00 am to 13:00 pm at the Health Insurance Institute of Slovenia (hereinafter referred to as HII). 14 out of 22 members of the national working group attended the conference: Nadja Čobal (Ministry of Health of the Republic of Slovenia), Katarina Železnik Logar (the Chamber of Craft and small business of Slovenia), Lučka Boehm (Association of Free Trade Unions of Slovenia), Dušan Nolimal (Institute of Public Health), Maja Zorko (Institute of Public Health), Nuša Konec (Institute of Public Health Celje), Blanka Kores (Psychiatric Clinic Ljubljana), Metoda Dodič Fikfak (Clinical Institute of Occupational, Traffic and Sports Medicine), Tanja Urdih Lazar (Clinical Institute of Occupational, Traffic and Sports Medicine), Eva Stergar (Clinical Institute of Occupational, Traffic and Sports Medicine), Vojko Strojnik (Sports Faculty, University of Ljubljana), Emilija Pirc Ćurić (Pension and Disability Insurance Institute of the Republic of Slovenia), Vesna Švab (Health Insurance Institute of Slovenia) and Boris Kramberger (Health Insurance Institute of Slovenia), who coordinated the conference. Due to work commitments, other members apologised for their absence; however they expressed the desire to participate in the next steps of creating a joint report on the current situation and future development in the field of promoting health in the workplace in Slovenia.

The conference took place in three parts:

1. Plenary presentations:
   – presentation of the aims and objectives of the JA MH WB – WP 6,
   – review of the situation in the field of mental health in the workplace in Slovenia,

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[24] The questionnaire is Supplement 1 of this document
[25] The programme of the SWOT conference is evident from Supplement 2 of this document

2. Discussion on the strengths, weaknesses, opportunities and risks regarding the promotion of mental health in the workplace, which was held in two groups:
   - consideration of measures for the promotion of mental health in the workplace,
   - consideration of measures to support workers already affected by mental and behavioural disorders;

3. Plenary report on the work in groups and conclusions.

The conference was mainly dedicated to discussing the strengths, weaknesses, opportunities and threats in the promotion of mental health in the workplace. The discussion took part in two working groups, where participants became acquainted with individual suggestions from members of the national working group, coordinated the given proposals and identified common challenges, solutions and recommendations regarding the promotion of mental health in the workplace. At the final plenary session of the seminar, all members of the national working group discussed and completed conclusions which resulted from the reports on the work in both groups.

On July 7, 2013, all members of the national working group received a short report on the SWOT analysis, together with the conclusions of the conference. They were asked to present amendments or modifying proposals. A second meeting of the national working group was announced, where the aim was to create final proposals.

The second meeting of the national working group was held on October 9, 2013 at the Health Insurance Institute of Slovenia, 10 members of the national working group attended the conference: Tatjana Čerin (Slovenian Chamber of Commerce), Maja Zorko (Institute of Public Health), Metoda Dodič Fikfak (Ljubljana University Medical Centre – Institute for Work, Traffic and Sport Medicine), Tanja Urdih Lazar (Clinical Institute of Occupational, Traffic and Sports Medicine), Eva Stergar (Clinical Institute of Occupational, Traffic and Sports Medicine), Vojko Strojnik (Sports Faculty, University of Ljubljana), Emilija Pirc Ćurić (Pension and Disability Insurance Institute of the Republic of Slovenia), Vesna Švab (Health Insurance Institute of Slovenia), Nena Bagari Bizjak (Health Insurance Institute of Slovenia) and Boris Kramberger (Health Insurance Institute of Slovenia), who coordinated the conference. At the meeting, the members of the national working group coordinated the following matters, on the basis of considering open questions:

- final recommendations for further measures in the field of promotion of health in both areas which were the subject of the SWOT analysis (measures to promote mental health and measures to support workers already affected)

- selection of models of good practice in the field of mental health in Slovenia which seem promising and therefore worth spreading

The third meeting of the national working group was held on Feburary 5, 2014 at the Health Insurance Institute of Slovenia, 5 members of the national working group attended the conference: Metoda Dodič Fikfak (Clinical Institute of Occupational, Traffic and Sports Medicine), Eva Stergar (Clinical Institute of Occupational, Traffic and Sports Medicine), Vojko Strojnik (Sports Faculty, University of Ljubljana), Samo Burnik (Pension and Disability Insurance Institute of the Republic) and Boris Kramberger (Health Insurance Institute of Slovenia), who coordinated the conference. At the meeting, the members of the national working group coordinated the following matters:

- information on progression of the project and exchange conference in Berlin, 29th and 30th of October, 2014

- active participation of the delegation from Slovenia in the exchange conference in Berlin

2.2. Basic information on (promotion of) mental health in Slovenia

Slovenia is a central European country with around 2 million inhabitants. In 2012 the Slovene gross domestic product (GDP) was at the level of €35,319 billion or €17,200 per capita. According to last data of Eurostat the Slovene gross domestic product per capita in terms of purchasing power parity achieves around 84 % of EU average – representing a 7 % fall in comparison with the year 2008 (91 % of EU average) before the economic crisis. In 2012, total expenditure on health was at the level of 9 % of GDP, €1,869 PPP per capita.

In Slovenia, mental health care has been prevailingly institutionalised – in hospitals and outpatient psychiatric clinics. The main mental health problems are high alcohol abuse, high suicidal index (25 − 30/100,000 per year), growing number of mental health disorders, increasing outpatient clinics visits etc. After the acceptance of the new Mental Health Act in 2008 new possibilities for coordinated community (mental) care and promotion of mental care for active population (mental care at worksite) have been established. On the basis of this act it is expected that the new national programme for mental health (to be accepted in 2014) should expose priorities such as promotion of mental health and prevention of mental disorders, fight against stigma and social exclusion, promotion of mental health and care for children and adolescents, promotion and care of mental health of the active population (at worksites), promotion of the care of mental health of elderly, community psychiatry, suicide prevention etc. The renewed Health and Safety at Work Act (2011) has introduced the obligation of employers who have to plan and implement the health promotion in the workplace.

Institutional framework of health and safety at work

The most important institutions covering health and safety at work are the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MoLFSAEQ) and the Ministry of Health (MoH). The MoLFSAEQ is responsible for the drafting of acts and other regulations concerning health and safety at work and the cooperation with other line Ministries in drafting individual regulations. Other tasks include the preparation of expert opinions, analyses, reports, information and other materials concerning health and safety at work, deciding on appeals against decisions of the Labour Inspectorate of the Republic of Slovenia, issuing work permits for carrying out professional tasks in the field of health and safety at work, issuing authorisations for carrying out trainings for health and safety co-ordinators at construction sites as well as international cooperation. Furthermore, it carries out tasks of the Slovenian Focal Point of the European Agency for Safety and Health at Work and promotes health and safety at work in Slovenia by organizing debates and publishing different materials and publications.

The MoH is monitoring and evaluating the level of health at work and preparing guidelines for health promotion at work place. The MoH is responsible for drafting regulations on health aspects of the health and safety at work, preventive check-ups, health promotion programmes, injuries at work and occupational diseases. The Labour Inspectorate of the Republic of Slovenia is an administrative body within the MoLFSAEQ. It shall carry out inspection of the implementation of laws, other regulations, collective agreements and general acts in the following areas, unless otherwise stipulated by laws: (1) health and safety at work, (2) labour relations, minimum wages, labor market and employment, labour and employment of foreigners, workers' participation in management and strikes. Other institutions and organisations in this field:

1. The Safety and Health at Work Council is an expert consultative body appointed by the minister responsible for labour (Article 62 of the Health and Safety at Work Act). It consists of experts in safety at work, occupational medicine, social security and experts representing employers' organisations and trade unions. Members of the Council representing employers' organisations and trade unions are appointed by the minister at the proposal of the Economic and Social Council. The Council discusses and adopts positions and recommendations on the situation, strategy and implementation of a uniform policy as well as on priority tasks in the field of health and safety at work.;

2. the Chamber for Safety and Health at Work which is an interest group of legal and natural entities which are authorised to perform expert tasks of safety and health at work;

3. educational institutions in the field of safety and health at work: the Department of Technical Safety of the Faculty of Chemistry and Chemical Technology at the University of Ljubljana, which educates safety engineers; the Chair of Public Health of the Faculty of Medicine at the University of Ljubljana, which implements undergraduate studies for students of occupational, traffic and sports medicine; the Department of Psychology at the University of Maribor which educates psychologists in occupational health psychology; the Medical Chamber of Slovenia, which implements the specialisation programme for doctors of occupational, traffic and sports medicine;

4. the Clinical Institute of Occupational, Traffic and Sports Medicine of Ljubljana University Medical Centre which conducts activities of health care of employees at primary, secondary and tertiary levels, and implements teaching, research-developmental and expert-methodological work in the field of protection and promotion of health of employees;

5. the Expanded Professional Board of Occupational, Traffic and Sports Medicine which is the highest independent expert authority for evaluating scientific achievements and verifying methods and the development of the discipline (including public health dimension);

6. the Expert Council for Occupational, Traffic and Sports Medicine which is an expert organisational body of the Slovenian Medical Association which, on the basis of expert criteria, epidemiologic and other data, drafts expert, economic and organisational documents for activities of occupational, traffic and sports medicine;

7. the Association of Slovenian Safety Engineers' Societies which is the umbrella organisation of engineers of safety at work and other experts implementing expert tasks in the field of safety and health at work;

8. the Association of Occupational, Traffic and Sports Medicine at the Slovenian Medical Association which is the umbrella interest expert organisation of specialists in occupational, traffic and sports medicine;

9. the Association of Occupational Health Psychologists at the Slovenian Association of Psychologists which is the umbrella interest organisation of psychologists working in the area of occupational health;

10. authorised providers of professional tasks in the field of safety at work;

11. occupational medicine providers who are united in a network of teams for occupational, traffic and sports medicine working within public and private institutions and performing tasks of health protection of employee in compliance with the Health and Safety at Work Act and regulations.

In compliance with Slovenian legislation, material obligations in the field of safety and health at work are shared by employers, the Health Insurance Institute of the Republic of Slovenia and the Pension and Disability Insurance Institute of the Republic of Slovenia, whereby employers should primarily assume a preventive role. According to the Occupational Health and Safety Act, the employee, the most vulnerable link in the system of safety and health at work, also has obligations. An important role should also be assumed particularly by employees' representatives for safety and health at work and trade unions. Safety and health at work is also frequently discussed by the tripartite Economic and Social Council, which includes representatives of governments, employers' organisations and trade unions, and tables questions and measures related to economic and social policy and other issues referring to special fields of partners' negotiations.

Mental health care of the active population

The Mental Health Act was passed in July 2008. Among other things the Act also anticipates a network of mental health programmes and service providers within the framework of public service and the adoption of a special national programme for mental health. The working group preparing a draft of the national programme was appointed in January 2009. It prepared a proposal for the national programme, with an action plan, which was also the subject of public discussion. However, a resolution on the national programme has not been adopted yet (i.e. until January 2014). The proposal for the national programme particularly discusses the mental health of the active population. One objective of the action plan is the maintenance and development of protection and the promotion programmes of mental health at work and for the unemployed.

According to the regulations on safety and health at work, the main obligation of every employer in Slovenia is to draft and adopt a safety statement with a risk assessment, with which the employer is supposed to adopt a policy and programme of measures for the comprehensive improvement of employees' position relating to injuries at work, health impairments, occupational diseases and diseases related to work, including employees' general well-being at work as reflected also in employees' mental health. The purpose of risk assessment is risk management and the prevention of health impairments. It has been established in practice that risk assessments in Slovenia are relatively incoherent. The assessments are relatively well prepared for risks whose management is based on rules (environmental risks and physiological burdens). Risks which are the result of poor work processes, poor organisation, unsuitable mutual relations, inconsistency between work requirements and employees' abilities, time pressure and lack of competence, are not defined sufficiently in majority of risk assessments.

According to the Health and Safety at Work Act, the active population is cared for by occupational medicine providers, authorised providers of professional tasks in the field of safety at work, occupational psychologists, human resources departments in companies and institutions, and advisors for the promotion of health at work. Among the tasks of about 140 occupational, traffic and sports medicine specialists is also promotion and protection of the mental health of the active population. The concessions for implementing occupational medicine activities are issued by local communities with the consent of the Ministry of Health. Some specialists of occupational medicine do not offer their services full time; about 5 occupational specialists work with the unemployed and in occupational rehabilitation procedures. Occupational medicine activities also include 25 psychologists, most within the basic health care service. Some are private providers working under the authorisation of the Ministry of Health.

Health promotion in Slovenian legislation

Slovenia has no common health strategy to promote the health of the population in the country and determine priority fields. National programmes or strategies in individual fields of health have been adopted – for example, in the field of drugs, physical activity, nutrition policy, etc.

When defining responsibilities for health the Health Care and Health Insurance Act mentions the issuing of regulations and measures to promote and protect health, the provision of conditions to raise health awareness and promote the development of healthy lifestyle habits by means of tax measures and economic policies. The Act also stipulates the establishment of a Health Council to implement these and other tasks of social care for health.

The Health and Safety at Work Act determines the rights and duties of employers and employees with respect to safe and healthy work and measures to ensure safety and health at work. According to the Act the employer shall plan and implement workplace health promotion (Article 6). Furthermore, the employer shall plan workplace health promotion, provide the necessary means for it and define the method for monitoring its implementation (Article 32).In this way the Health and Safety at Work Act defines health promotion as systematically-oriented activities and measures which the employer implements to maintain and strengthen the physical and mental health of employees. The Act also stipulates that the Ministry of Health shall issue guidelines on specifying and preparing workplace health promotion.

Almost 200 advisors for workplace health promotion are trained. They have acquired their training as advisors for workplace health promotion implemented by the Clinical Institute of Occupational, Traffic and Sports Medicine of Ljubljana University Medical Centre. The network of providers is small but quite equally distributed in Slovenia.

However, it should be mentioned that the Resolution on National Programme of Safety and Health at Work – adopted by the National Assembly of the Republic of Slovenia in 2003 – takes into account the guidelines and recommendations of international law, in particular ILO Convention No. 155 concerning Occupational Safety and Health and the Working Environment. According to the chapter on promotion of the prevention culture – the MoLFSAEQ shall mainstream OSH into education. Furthermore the MoLFSAEQ and MoH shall in cooperation with social partners and other institutions carry out projects promoting safety and health at workplace, publish brochures, leaflets and posters – intended for awareness raising of individual target groups.

3. Results of the SWOT analysis

Individual responses to the SWOT questionnaire and discussion by the members of the national working group at the SWOT conference suggested a wide range of challenges which are related to the legal, organisational, financial, technical and other aspects of the implementation of measures to promote mental health in the workplace in Slovenia. The results of the SWOT analysis, in accordance with the described approach, are given below. They include (1) individual assessments and proposals, (2) the assessment of the situation and the development potential, coordinated at the conference and (3) closing recommendations and the choice of good practice models.

3.1. Individual assessments and proposals on the basis of the SWOT questionnaire

On the basis of individual responses of members of the national working group, the following strengths in the field of measures for promoting health in the workplace[26] were recorded:

- legal regulation of the promotion of mental health in the workplace in Slovenia:

a. since 2011, employers are bound by the Health and Safety at Work Act (hereinafter referred to as ZVZD-1/UL RS, No. 43/2011) to plan and implement the promotion of health in the workplace and to take steps to prevent violence, bullying, molestation and psychosocial risk;

b. the Employment Relationships Act (hereinafter referred to as ZDR-1/UL RS, No. 21/2013) and the Penal Code (hereinafter referred to as KZ-1/UL RS, No. 55/2008) show the public a greater concern for mental distress in the workplace;

c. In Slovenia, several statutory rights have a positive impact on the physical and mental health of workers (for example, the right to breaks during work, paid lunch, the right to work part-time, parental rights, right to paid sick leave, including for a longer period of time – for example, during rehabilitation in cases of mental illness, etc.);

d. mandatory periodic preventive medical examinations for workers

- case law (criminal and damages law) is emerging which sanctions (the tolerance of) violence, discrimination and harassment/mobbing in the workplace;

- managing psychosocial burdens in the workplace, which is included in the work programmes of social partners at the national level (trade unions and employers' organisations);

- a relatively good network and organisation of providers (work, traffic and sports medicine, engineers of safety at work);

- several campaigns to promote health and raise awareness (tips for healthy living, encouraging training and physical activities, promote healthy food, etc.);

- several national campaigns on safety and health at work were carried out in the period 2002–2013 by the MoLFSAEQ in cooperation with the tripartite National Network for cooperation with EU-OSHA; in April this year the Healthy Workplaces Campaign 2014–2015: "Managing stress and psychosocial risks at work" is going to be launched; activities will be partly covered by EU-OSHA and partly by MoLFSAEQ;

- the national web site on safety and health at work *(http://www.osha.mddsz.gov.si)* provides various useful information for employers and workers, including on-line applications and handbooks;

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[26] In accordance with the protocol and the methodology of the project the term "promotion of mental health" relates to measures which are implemented to protect and promote health in the workplace, where mental burdens occur. Those are measures for health and safety at work, implemented inside or outside of companies/organisations and measures of promotion health in the workplace.

- several educational activities for the promotion of health in the workplace (educational courses, manuals for planning promotion of health, live performances on basics of safety and health at work for children aged 5 to 8 and 9 to 11, promotion of Napo films and Napo Teacher's Toolkit etc.);

- a network of 120 advisers for promotion of health in the workplace exists across Slovenia;

- various successful projects of promotion of health in the workplace (mainly funded by the EU);

- various analyses and research in the field of the promotion of mental health (for example, regular databases of the Institute of Public Health on sick leave, various indicators of mental health etc., the Eurofound report "Psychosocial risks in the workplace in Slovenia" financed partly by the MoLFSAEQetc.);

- various approaches to promoting health in the workplace allow employers to adjust to their own needs and available financial resources;

- some examples of good practice which could have been transferred to all companies (for example programmes like "Family-friendly companies", "Work – in harmony with life"; "Fit for Work", etc.);

- advertising positive values:

a. recognition that without integrity in the workplace, (corporate) social responsibility and business/work ethics, there is no progress in the field of health promotion;

b. awareness of some individuals and business managements of the importance of good mental health and knowledge about promoting mental health is increasing;

c. large companies ask for consultants and mental health services for their employees.

Members of the national working group highlighted the following weaknesses in the implementation of measures of health promotion in the workplace:

- good legislation does not guarantee that health promotion measures will actually be implemented;

- performers of the promotion of health in the workplace are too dependent on employers, contractually or financially;

- corruption, different criteria for different individuals, insufficient possibilities to participate in work processes;

- most companies do not have or do not implement plans to promote health in the workplace, poor conditions for implementing programmes, employers are generally not qualified to carry out such measures; most of them find it hard to afford professional assistance of external qualified performers; employers are focused on improving productivity at any cost;

- the programme is feasible in larger companies with many employees; a similar programme for small business and craft workers is not available;

- disadvantages arising from the current crisis situation: uncertainty; what will happen with the job (change in employment type, reduction of labour rights, fear of job loss); changed job requirement (higher productivity, fewer employees, unclear requirements, informal extension of working hours);

- workers have difficulties in exercising rights for various reasons (type of work, unwillingness, insufficient knowledge on rights);

- still too much stigmatisation and discrimination of less healthy workers;

- inspection services find it difficult to supervise the fulfilment of obligations by employers and the exercise of rights by employees lack of coordination, duplication, lack of cooperation, unhealthy competition – the ineffectiveness of programme managers;

- management often does not support educated programme managers-promoters in the implementation of activities;

- absence of a national programme for mental health; there is no national strategy for both the general field of health promotion as well as for the promotion of (mental) health in the workplace; therefore, employers take different approaches to meeting statutory obligations;

- there are no national guidelines for health and mental health promotion (in accordance with paragraph 2, Article 32 of ZVZD-1/UL RS, No. 43/2011);

- there are no state resources for projects for managing psychosocial burdens in the workplace;

- lack of cooperation between key stakeholders at the national level, such as between the two ministries, the Institute of Public Health and the Institute for Sustainable Development and between other stakeholders;

- lack of research and measures based on analyses; poor knowledge of the situation; no records of the situation; information on addictions and on mental and behavioural disorders is not used enough; no quality and comprehensive analyses, usually only partial considerations;

- measures are mostly implemented partially and at the primary level; poor participation of authorised physicians of work, traffic and sports medicine and personal physicians;

- irregular periodic medical examinations; mental health is not considered enough; too little emphasis on the prevention and promotion of physical health;

- lack of easy, fast and affordable counseling programmes and psycotherapeutic help when a person does not need medication yet, but only encouragment and guidance to activate their own potential;

- lack of methods for maintaining mental health and well-being;

- no regular information or public campaigns to spread good practices in the field of protecting and promotingmental health in the workplace;

- lack of professionally verified health promotion programmes in the workplace;

- simplification and trivialisation of the seriousness of the problem;

- general erosion of integrity, including scientific integrity;
family values are moving to the working area – opportunities or threats for the family or the workplace.

Members of the national working group observed the following opportunities for implementing the promotion of health in the workplace in the future:

- creation of a development vision and strategy for health promotion in Slovenia, preparation of the National programme for mental health;

- defining standards for promotion of health in the workplace with the proposal of contents and methods in the law or by-laws;

- social partners (trade unions, employers' associations) in Slovenia are already acquiring knowledge, skills and tools to manage psychosocial burdens in the workplace which can be used at the level of individual employers;

- HII supports projects of social partners with the public tender for co-financing projects for the promotion of health in the workplace (published in the Official Gazette, No. 35/2013 on 2013), which will enable a faster build-up of knowledge and tools;

- with the help of European assets and connections, the Institute for Work, Traffic and Sport Medicine transfers good practice to Slovenia;

- European campaigns (for example, *(https://osha.europa.eu/sl/campaigns/)* for the dissemination of good practices; the possibility of raising money from European funds on the basis of specific projects;

- European social partners conclude European agreements binding on national social partners (e.g. work-related stress, harassment and violence in the workplace – see *http://www.sindikatzsss.si/index.php?option=com_content&view=article&id=604&Itemid=209*);

- it is possible to develop a network of trained mediators, specialists for the resolution of conflicts in the workplace which are a source of mobbing, violence, intimidation at work, etc.;

- case law could support proactive actions by employers to prevent the escalation of conflicts in the workplace;

- develop worker-friendly environments in accordance with their needs and characteristics;

- employment of people with disabilities;

- adapting jobs to people with mental disorders and lower abilities;

- connecting with the non-governmental sector, civil society, anti-discrimination movements, cooperation with voluntary (non-governmental) organisations;

- mobilisation of internal positive reserves and trying to find positive examples (foreign as well) of good practice promoting a positive approach to work, health, life, etc.;

- improving the organisation of work and working environment (interpersonal relations, communication, group activities);

- improving activites for healthy personal development (stress management, mutual trust, etc.);

- connecting with neighbouring and distant countries and organisations in order to transfer knowledge and experience;

- health promotion as an integral part of the activities for the "recovery" of the country and a way out of the crisis, which is based on giving authority to citizens; crisis as a chance to begin activities in the field of health promotion;

- switch from pessimism to optimism;

- informing the public (general, specific – employers, workers, social partners, civil servants etc.) about health (no health without mental health!); a comprehensive system of awareness, motivation and support increasing the awareness of the importance of health in the workplace at all levels – campaigns, education;

- educating consultants for the promotion of health in the workplace;

- expansion of the network to implement promotion of health in the workplace;

- regulation of the legal, judicial and social state;

- changes in labour legislation to allow the better implementation of active policies for the promotion of mental health in the workplace; changes in legislation for specific promotion and to support employers and employees (benefits);

- providing a healthy working environment (physical environment, health care for workers, appropriate management;

- increased implementation of different ways to adapt work processes and jobs that are favorable to workers wherever possible (for example, flexible working hours, work at home, a large number of breaks etc.);

- promotion of values and attention for vulnerable groups;

- the possibility of training and integration in the form of volunteer activities;

- inclusion of relevant content into education and training programmes at different levels;

- participation of insurance companies;

- inclusion of key approaches/professions to address issues;

- improve regular monitoring and research – exploration, development and improvement of the quality of key indicators and all other research activities; it is necessary to improve the quality, quantity and timeliness of reporting data; obtain data, which is comparable to data from other EU member states; more research and evaluation activities to better understand the situation in the field of alcohol, illegal drugs and mental health in workplaces in Slovenia;

- establish a good information network in Slovenia and good cooperation with the information network of the EU;

- ensure the transfer of models of good practice from the EU to Slovenia;

- combine capacities and increasing the efficiency and responsiveness of the protection and promotion of mental/psychosocial health in the workplace at the national level (especially the role of the Institute of Public Health; define the key tasks, responsible persons , the operation protocol, etc.);

- improve cross-sectoral and multi-disciplinary work and rewards – therefore integration with external experts and other institutions is very important, and therefore threats to this cooperation present a significant risk;

- coordinate work and responsibilities of individuals with expectations regarding the law, professionally acceptable goals and codes of ethics;

- development and implementation of prevention programmes to enhance the mental and physical strength of individuals (from childhood on, with general and specific programmes, measures...), which will be verified and systematically (obligatory) included in a system of schooling and work;

- connecting work, traffic and sports medicine with public health (Institute of Public Health, Health Insurance Institute of Slovenia) in the preparation and implementation of joint programme to promote health in the workplace

- revive the Fit for Work programme (adding content on the promotion of mental health and stress management) and adapt it to small businesses and tradesmen;

- systemic regulation of consultation offices for psychological and psychotherapeutic support with high availability throughout the country, following the example of existing ones.

In individual responses to the SWOT questionnaire, members of the national working group identified the following threats related to implementing the promotion of health in the workplace in the future:

- in times of economic crisis, when jobs are lost, when work does not provide enough funds for a decent life, sensitivity to the psychosocial distress of individuals can decline even further;

- employers are less ready to adapt to necessary amendments and changes to the legislation in times of crisis;

- there is a risk that, due to lack of funds, the necessary activities for monitoring the problems, for obtaining quality, objective, reliable and comparable information, for the creating national and other policies and for decision-making are not implemented;

- the lack of information systems for analysing the situation in the field of alcohol and drug abuse and mental health in the workplace in Slovenia;

- the stress due to fear of losing jobs can greatly increase;

- in the case of small and micro-employers, it is possible that there will be even less knowledge and fewer capacities for high-quality job creation;

- willingness to spread knowledge and skills of work organizers, such as skills to communicate with employees is decreasing; employees are handled through intimidation;

- the Labour Inspectorate may even less proactively intervene in cases of complaints of workers due to mobbing (e.g. to order the employer undertake a mediation process);

- it is possible that the Ministry of Health will not draw up guidelines to promote health within a reasonable period or the guidelines will be unfriendly for use by employers;

- the fear of adapting jobs to people with fewer opportunities due to prejudice and real needs to change work processes could increase;

- it is possible that discriminatory actions due to complications or errors in the change process will increase;

- it is possible that health promotion as an innovation will be rejected even more, since future measures can largely lean on already established and managed measures;

- it can come to diversion of funds to improve working conditions to different programmes that are unevenly or unequally accessible and of dubious quality;

- deepening the crisis and unfavorable conditions for development in the promotion of mental health:

    - reduction in the number of employees – more mental and physical burdens on remaining workers

    - increasing stratification and poverty

    - increasingly debilitating and stressful work

    - due to the fear of losing jobs, people work beyond their capabilities, which can result in illness, injury, chronic fatigue and exhaustion,

    - harsh working conditions increase the risk of mental disorders (reduction in the number of employees and increasing demands at the workplace)

    - risk of delayed recognition of diseases and the danger of concealment thereof

    - risk of increasing addiction

    - risk of resignation, paralysis, lack of creativity and innovation

    - in the event of a further deterioration in the economic situation, there will be even fewer resources available to implementin the promotion of health in the workplace

    - the deterioration in the economic situation and job insecurity can also cause a reduction in workers' rights, labour disputes, stress, a deterioration in the mental health of the working-age population, questionable staffing and corruption;

- shutting down health promotion activities in the health sector; the activities become an end in themselves and fail; negative trends in the development of primary health care;

- unpredictable work and actions in the field of health and safety at work: even outside regular working hours, a number of additional "ad hoc" tasks that do not fall within the scope of the project and are not planned, allocated by both the Ministry of Health, Ministry of Labour and international organisations; unplanned tasks interfere with the working process; because stakeholders lack time, they carry out tasks late and thus hinder the work of others and cause delay;

- lack of a critical mass of researchers, professionals and designers of health policies; the risk that there will be no transition from words (documents) to actions;

- poor cross-sectoral collaboration; unclear responsibilities of individual institutions; a mismatch in the development of actions among sectors; fear of losing programmes and, consequently, money;

- too many scattered programmes; programmes are of short duration; areas of work are too vaguely delimited between providers; unstable sources of funding ;

- standards in the promotion of mental health may be unrealistic (too high or too low).

With regard to measures to improve the situation, members of the national working group expressed the following individual recommendations to promote health in the workplace in Slovenia:

- drawing up a strategy for the promotion of health (including mental health promotion), a clear development vision of the country, what it wants to achieve in the area of public health, creation of a national programme for mental health;

- ensuring conditions for the implementation of mental health promotion measures: fiscal policy, insurance law, professional support/programmes for the protection and improvement of mental health (occupational medicine, psychology, kinesiology, nutrition, organisational science, information technology, etc.);

- implementation of public awareness campaigns; promoting a positive approach to health, work, life; promoting responsible behaviour by all people involved;

- formulation of guidelines for good practice at the level of the employer in consultation with social partners;

- introduction of a differentiated system for employers who demonstrate good care for the health and safety of their workers, have fewer days of sick leave, injuries at work; the contribution rate for such employers should be lower;

- training of (union) trustees for workers for the acquisition of the skills of representing workers who seek help due to mobbing, violence, harassment, discrimination, etc.;

- fast and effective procedures in the event of such complaints (determination of a trustworthy person, mediation, etc.) in collective agreements;

- training of the labour inspectorate for a proactive role in cases of complaints;

- elaboration of approaches and methods of operation to carry out the promotion of mental health in workplaces and recommendations;

- preparation and implementation of uniform verified programmes in the field of strengthening mental health in all working organisations, working for all employees and especially for vulnerable groups (e.g. pregnant women, employees before retirement, lower paid workers, chronically ill workers, workers with mental health problems, workers who are under greater psychological stress, certain service professions with a greater burden) with measures in the event of non-implementation;

- clearly designed plans for the promotion of health in the workplace, with short-term objectives and the active participation of workers and employers (direct contact), with an emphasis on interpersonal relations, and the maintenance of personal physical, psychological and social balance;

- strengthening links between sectors and professions in providing assistance in the implementation of promotion and prevention; design protocols of cooperation between sectors;

- defining obligations, rights and duties in the workplace and beyond as clearly as possible; consistency in the implementation, monitoring and punishment of offenders;

- implementation and control of the implementation of existing legislative measures (rights) and consistent measures in case of violations;

- adjustment of individual processes within work processes so that persons with mental health problems are able to carry them out (possible break-down of spheres of work);

- adapted training; continuous promotion measures in the form of presenting models of good practice;

- active involvement of staff sectors to implement a policy for health promotion;

- development, monitoring and improving the quality of key indicators and all other research activities, as well as the applicability of key indicators and other epidemiological information activities; it is necessary to link research with policy and the better use of data;

- integrate concepts in the field of health promotion with the concept of integrity in the workplace and (corporate and other) social responsibility or business/work ethics into the promotion of health in the workplace or health and safety at work.

Based on the individual responses of members of the national working group, the following strenghts in the implementation of measures to support workers who are already affected by behavioural and mental disorders were identified[27]:

- we have the Mental Health Act;

- in certain work environments, they are trying to adapt to individuals with mental disabilities and provide them support; we have individual projects – examples of good practice;

- in some environments, the efficient vocational rehabilitation and retraining for people who have mental health problems takes place;

- possibility of disability retirement on a smaller scale; the possibility of an adjustment to the Law on Pension and Disability Insurance (shortening working time – for example, part-time; other adjustments);

- possibility of employment in the form of support or protection by the Vocational Rehabilitation and Employment of Disabled Persons – ZZRZI;

- there are certain organisations that specialise in the employment of people with disabilities and people with mental health problems (so-called sheltered workshops);

- possibility of the organisation of working time and work at home;

- opportunity for inter-ministerial cooperation between multiple stakeholders and strengthening thereof;

- projects and legislation on workplace bullying;

- in the past, several major projects were developed that dealt with the work component of affected people;

- we have knowledge of the problems and consequences of bullying, issues of stigmatiastion and discrimination to support those affected by mental and behavioural disorders;

- coordinators of Community in Social Work Centres also do good work.

Members of the national working group highlighted the following weaknesses in the implementation of measures to support workers who are already affected by behavioural and mental disorders;

- lack of appropriate legislation, strategies and action plans on this and in the wider field of protecting the mental health of employees;

- lack of a national programme for mental health;

- the system does not favour supporting vulnerable and disadvantaged groups;

- lack of cooperation between key stakeholders, absence of links reduces efficiency;

- adjusted jobs for people with mental disorders are not sufficiently widespread except in rare companies founded by non-governmental organisations;

- problems of integration into the work process or staff are common, stigmatisation (lack of understanding of superiors or colleagues of the health status of workers, the inability to adapt the workplace or workflow);

- increasingly stringent conditions of the Health Insurance Institute and the Institute for Pension and Disability Insurance of Slovenia in the granting of sick leave and disability pension award;

- lack of jobs and consequently faster lay-offs of workers who are frequently absent due to illness;

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[27] In accordance with protocol and the methodology of the project, the 2nd set of the SWOT questionnaire related to measures, implemented to support workers, who are already affected by mental and behavioural disorders. Those are measures for the integration into the company/organisation, gradual reintegration, social counselling measures, carried out inside or outside of companies/organisations and health care, carried out inside or outside of companies/organisations

- the quota system has degenerated; too many restrictions on the use of funds from the quota;

- uneven burden on other workers;

- difficulties in organising teamwork;

- neglect of the field of mental health; measures at the state level are not sufficient or relatively unknown;

- the employer can have serious problems in the event of employing a worker with mental and behavioural disorders if he can not provide the employee another workplace, and a negative assessment of the occupational health services is not a sufficient reason for dismissal;

- employers do not have adequate knowledge and financial resources to implement measures;

- differences between individual regions;

- lack of respect for previous knowledge and expertise (reinventing the wheel);

- obstruction of work and the stigma attached to those who work in this field;

- no quality programmes;

- staff burnout, due to long-term neglect of this field; there was a shortage of staff and also new knowledge in this field;

- there is no evaluation of measures to help those affected;

- services are provided to persons with serious mental illness who are mostly unemployed.

In individual responses, the members of the national working group identified the following opportunites for the implementation of measures to support workers who are already affected by behavioural and mental disorders:

- introduction of appropriate measures and active policies in the field employment of workers with mental health problems (eg. appropriate adjustments of jobs, active involvement of such workers in the labour process etc.);

- preparation of the national programme for mental health

- opportunity to start cooperation between various actors, governmental sectors;

- implementation of social entrepreneurship and prioritizing employment of people, who have been greatly distanced from the labour market so far (social inclusion, structure of the day, a fair income, social identity etc.);

- introduction of a quota system in employment (the organisation must employ a certain percentage of people, greatly distanced from the labour market, for example people with disabilities and mental health problems);

- expanding the possibilities of using funds from the quota, also for rewarding workers who assume tasks;

- provide tailored forms of employment for people with mental disorders with financial incentives;

- reducing stigma, the right to work and employment for people with mental health disorders, de-stigmatizing (research, projects);

- access to psychosocial help in companies – e.g. psychotherapy, counseling, trustee, directing to relevant special services;

- a greater flexibility of the working time and adaptability to users;

- employment of persons with preserved intellectual potential in the workplace, that require or enable impersonal communication;

- implementation of active employment policy;

- develop the concept of psychopathy at the workplace with victimization or effects on the mental health of employees (research, prevention);

- staffing of experts who desire to work in this field;

- transfer of knowledge, education and provision of additional education of recruits, connecting and communication, education at the national level;

- protection of experts ("whistleblowers");

- monitoring and evaluation measures will allow the assessment of whether a particular programme, measure or policy success is successful, and to what extent it requires changes;

- introduction and development of innovative programmes/companies, adapted for people with mental and behavioral disorders;

- introduction of a community psychiatry, which will integrate (social) treatment in the community with medical treatment and offer even greater support to people with severe mental health problems and their integration into national, local, and work environment.

In individual responses to the SWOT questionnaire, members of the national working group identified the following threats in the field of implementing measures to support workers already affected by behavioural and mental disorders:

- due to rising unemployment and lack of jobs, competition for new/existing jobs is increasing, which means far fewer opportunities for workers affected by mental and behavioural disorders;

- reducing sick leave compensation can lead to increased poverty;

- lack of financial resources or volatility of funding (both on the part of employers and the state) to support specific programmes to employ people with mental health problems; due to the reduction in public funds, it can expected that the resources to work on these activities will be reduced;

- system abuse and tricking people who cannot defend themselves;

- burdening people with problems in less favourable forms of working time;

- excessive burden due to "working time unaccounted for";

- lack of suitable jobs for workers already suffering from mental and behavioural disorders;

- partial measures, lack of cooperation of actors;

- adoption of new legislation, new strategy and action plan in this field is not in sight, which means on the one hand ensuring work continues and, on the other hand, new debts;

- because the system is relatively complicated and complex and needs many activities before it changes, fast transitions are unlikely to happen;

- continued practice of disrupting work and stigmatising professionals who want to support workers with such disorders (current culture and practice is that such workers are laid off or not employed);

- quick replacement of personnel (members of groups who are responsible for specific tasks), resulting in poor transfer of knowledge to new employees; new workers have very little experience and no specific knowledge; in Slovenia there is otherwise a relatively small number of experts in this field;

- unclear responsibilities of the operator who prepares the programme.

Regarding measures to improve the situation, members of the national working group expressed the following individual recommendations in the field of measures to support workers already affected by behavioural and mental disorders:

- strengthen social enterprises and cooperatives (social entrepreneurship), and improve employment opportunities for vulnerable groups, which contributes to tolerance and improved social relations;

- introduction of active labour market policies to employ people with mental health problems;

- implementation of a programme of vocational rehabilitation in workplaces;

- introduction of programmes in accordance with the recommendations and with domestic and foreign examples of good practice;

- introduction of psychosocial assistance in companies (trustees, psychotherapy, counselling) and a variety of activities to promote mental health;

- persons who are already affected and have the status of a disabled person should not be counted for the quota of employees;

- expanding possibilities of integrating into various fields of work (volunteering, contracts, casual work) in a way that rights already obtained (with an emphasis on the importance of rehabilitation and integration) are preserved;

- advantages to integration in public works;

- establishment of strong social networks, as in Scandinavian countries;

- implementing additional education for all involved;

- strengthening projects of to reduce stigmatisation;

- continuous monitoring and evaluation of measures; the greatest value of the evaluation is to identify different stakeholders;

- health insurance will cover costs of individual and group psychotherapy.

3.2. Assessment of the situation and development prospects – coordinated views at the SWOT conference

At the SWOT conference, members of the national working group initially became acquainted with analytical data on the situation in the field of mental health in the workplace. Afterwards, members divided into two working groups, and on the basis of the final plenary debate, unified views on identified advantages, disadvantages, opportunities and risks in the field of promoting mental health in the workplace in Slovenia.

Mental health of workers – review of the situation

Firstly, an analytical overview of the state of mental and behavioral disorders in the workplace in Slovenia was presented at the SWOT conference (see figure 1). The overview was derived from routine indicators of sick leave and data from some national research in this field[28].
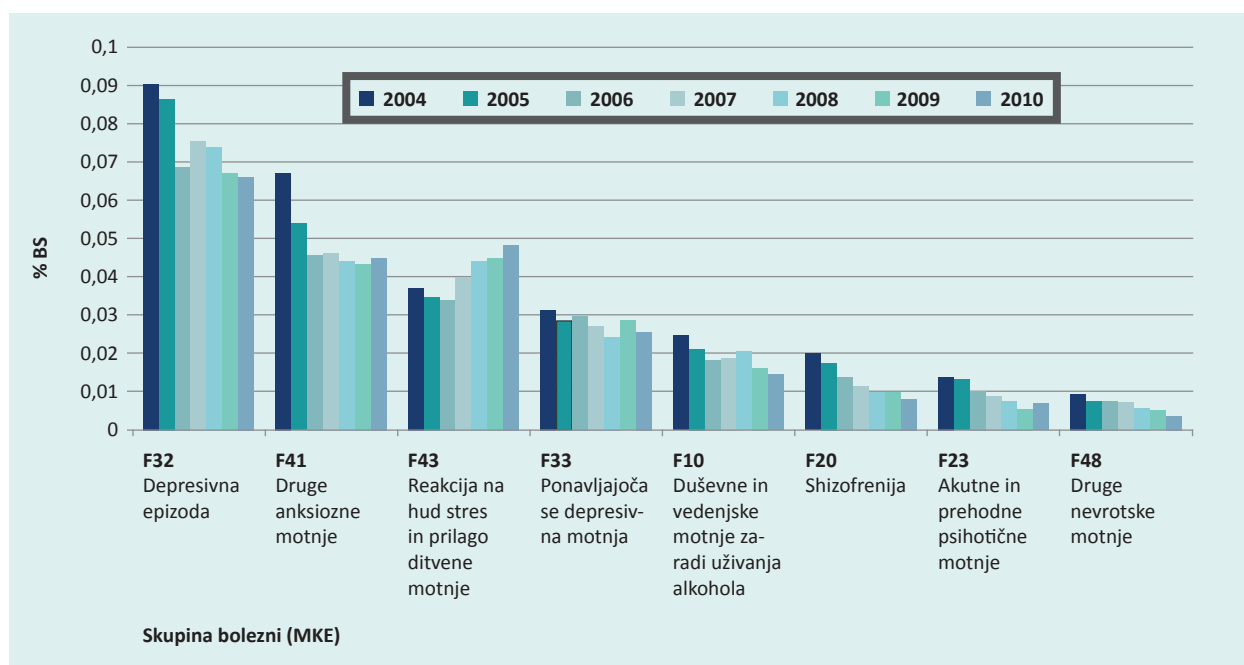

Figure 1: SL percentage, mental and behavioural disorders according to diagnoses, 2004–2010 (Source: Institute of Public Health of the Republic of Slovenia)

The results of accessible national files on the health of workers indicate that the economic crisis has had a substantial impact on the health of workers. In the first year of the crisis, the percentage of sick leave dropped sharply; however, it increased significantly in industries most affected by the crisis. Among mental and behavioural disorders, sick leave is rising significantly due to the reaction to severe stress and adjustment disorders; in the second year of the crisis, it also rose due to myocardial infarction. Presenteeism is expressed in the group of mental and behavioural disorders (hereinafter referred to as MBD); however, some diagnoses of mental and behavioural disorders and some cardiovascular diseases present a greater seriousness. What should also be noted is the higher number of suicides in 2009 compared to 2008.

Coordinated assessments and possibilities regarding measures of mental health promotion

Members of the national working group unified views on the following strengths, disadvantages, opportunities and risks in the field of promoting mental health in the workplace in the future:

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[28] Overview of the situation of mental health in the workplace is Supplement 3 of this document

Strengths:

- the legislation provides a sound basis for the implementation of promoting health in the workplace (Employment Relations Act ERA -1, the Law on Safety and Health at Work ZVZD -1, Civil Servants Acts, Integrity and preventing corruption Act);

- defined codes of ethics and standards at the level of employers' organisations are important for the implementing the promotion of health;

- certain options for financing projects have expanded – European projects; public tender for co-financing by Health Insurance Institute; public tender for co-financing by the Ministry of Health; public tender for co-financing by the Ministry of Labour, Family, Social Affairs and Equal Opportunities;

- more research in this field – research on the prevalence of drugs, bullying, stress, lifestyle research in the general population, regular statistics;

- domestic knowledge (know-how) exists for the implementation the promotion of health – Institute of Occupational, Traffic and Sports Medicine, IPH, private institutions, trade unions, employers' organisations;

- numerous programmes and projects in companies, that are recognised as good practice – the project "Fit for Work"; the project "Counselling centres"(IPH Celje), general programmes for a healthy lifestyle mediation to resolve conflicts in the workplace;

- certificates for companies are being developed – family-friendly company, OHSAS;

- there is a wide network of non-governmental organisations in the field of mental health.

Weaknesses:

- the legislation does not provide enough implementing bases for the exercise of measures to promote health:
  - the absence of a comprehensive strategy in the field of health promotion (promotion and prevention) and in the promotion of mental health;
  - absence of a national programme for mental health;
  - a flaw in the Occupational Health and Safety Act (OHS-1) – no guidelines for health promotion in the work place.

- lack of comprehensive inter-sectoral prevention policies, entrapment of (mental) health in the health sector;

- disadvantages in the implementation of projects:
  - inadequate preparation of tenders (unclear objectives, partiality);
  - lack of continuity; it is not possible to reasonably rely on financial resources;
  - duplication of subjects; absence of certain subjects;
  - the performance of projects (evaluation) is not assessed;
  - health promotion projects are not adapted to small companies.

- policies and health promotion projects are not based on analyses;

- inadequate, unsystematic and uncoordinated funding of applied projects and research;

- it is impossible to link databases due to different operators and the Law on the protection of personal data;

- lack of integration and inter-ministerial cooperation with clear competences and responsibilities;

- lack of national research on the health in the workplace and labour market;

- absence of periodic reports on the health of workers;

- the weak role of occupational, traffic and sports medicine, and services for health and safety at work in the promotion of (mental) health and mental health; lack of psychosocial risks in risk assessments and, consequently, in periodic inspections;

- poor cooperation between occupational, traffic and sports medicine doctors and personal physicians and public health institutions;

- lack of knowledge about the (mental) health and educational programmes offered at various levels of education and training;

- inconsistent information for employers (credibility of sources and information);

- no other health promotion programmes for the working-age population;

- lack of programmes for advising companies (employers and workers);

- the role of the Labour Inspectorate of the Republic of Slovenia on psychosocial risks;

- non-integrated concept of social responsibility in health promotion projects.

Opportunities:

- a crisis is an opportunity to move from pessimism to optimism;

- a crisis can be a challenge for the immediate creation of a new vision of development and health strategy, focusing on the development and implementation of programmes to enhance mental strengths (systematically placed in the education and work system);

- a very big challenge for the future is to link integrity concepts, social responsibility and the promotion of (mental) health;

- carry out comprehensive informing and learning for different public groups (decision-makers, social partners, professional public employees, workers);

- benefit from the potential of existing networks of social partners, professional institutions and non-governmental organisations;

- support the participatory method of leadership;

- use European assets and implement appropriate national campaigns;

- mental health promotion programmes are an opportunity in times of increasing years of service;

- preparation of protocols or cross-sectoral, inter-institutional and interdisciplinary cooperation;

- expansion of the health promotion network at various levels;

- creation of new jobs;

- intergenerational cooperation in the workplace through the mentoring approach;

- definition of guidelines and standards for health promotion with the proposal of subjects and methods.

Threats:

- a crisis can be an excuse for paralysis (risk that creativity and innovation diminish, brain drain, creaming-off effect);

- lack of overall health strategy;

- prolonging years of service;

- undefined workday;

- restricting (mental) health to the health sector;

- decision makers do not take health into account as a condition or factor for economic growth;

- erosion of integrity;

- health is not taken into account in corporate restructuring;

- dependence of decisions and priorities on the current political structure;

- great diversity, time limits and unpredictability of work in the field of mental health;

- precarious persons, the unemployed, young workers, migrants and first job seekers are not included in measures of health promotion.

At the end of the discussion, members of the national working group favoured the following joint recommendations in the field of promoting mental health in the workplace:

- create a government vision for health;

- adopt a national strategy and national programme for mental health;

- identify protocols of interdepartmental cooperation and inter-ministerial provision of sources for projects which fully cover the field of promotion of (mental) health of the active population and can become health promotion programmes (the key is implementation and then evaluation);

- sensitisation and education of various stakeholders for the promotion of health, both formally and informally, is crucial;

- (economic) programmes of restructuring should take people and their (mental) health into account.

Coordinated assessments of the situation and possibilities regarding measures for workers who are already affected

Members of the national working group unified views on the following strengths, weaknesses, opportunities and threats in measures to support workers who are already affected by behavioural and mental disorders:

Strengths:

- on the basis of the Occupational Safety and Health Act (OSH-1), health promotion is a legal obligation of employers in Slovenia;

- quotas for the employment of people with disabilities has led to progress in this field;

- Slovenia has a established a regulated system for assessing disability;

- sheltered workshops as organisations, that "specialise" in employing people with disabilities or people with mental health problems;

- examples of good practice in Slovenia are social companies for people with fewer opportunities.

Weaknesses:

- despite the legal obligation, programmes to promote (mental) health are not carried out in companies;

- labour legislation in Slovenia is not flexible in terms of how work is done, in particular to adapt working practices and requirements;

- there are no real incentives for employers to employ people with disabilities;

- the actual status, care and protection of people with disabilities (especially in times of crisis) are bad

- programmes of employment, tailored employment and training for employment for people with disabilities are not accessible or sufficiently available;

- the establishment of disability (social) enterprises is not equally friendly (accessible) for all profiles of disability;

- the system of people with disabilities returning to work after a long period of sick leave is not flexible;

- the attitude to work, which can also be seen in relation to the categories of affected employees, is a general problem in Slovenia.

Opportunities:

- strengthening (financial) incentives for employers in employing people with disabilities or workers with mental or behavioural disorders;

- spreading information and education programmes on the issue;

- care for people with disabilities must be established as a quality standard for employers, as well as a value and measure of corporate social responsibility;

- it is necessary to establish the systematic promotion of funding social enterprises or cooperatives;

- strengthening (financial) responsibilities of employers for promoting health in the workplace;

- establishment of a permanent body (guardian) for mental health in the workplace;

- implementation of a national (media) campaign for the promotion of mental health in the workplace;

- establishment of a highly adaptable system of patients returning to the work process after prolonged sick leave;

- establishment of flexible options to carry out work for people with disabilities (work at home, etc.);

- promoting a good organisational atmosphere and relations in the workplace as a solution or exit from the crisis and/or as a business or social value.

Threats:

- health problems in the workplace are not a priority activity for employers in times of crisis;

- crisis as an excuse to deepen discrimination and stigmatisation of categorised workers/people with disabilities;

- certain groups of people with disabilities (who are not well organised) could remain outside the system;

- crisis as an excuse for abandoning health promotion programmes in the workplace.

At the end of the discussion, members of the national working group favoured the following joint recommendations in the field of supporting workers already affected by behavioural and mental disorders:

- establishment of a uniform (interministerial) development strategy concerning mental health in the workplace, which includes;

- harmonised solutions for various stakeholders regarding measures to support workers who are already affected by mental and behavioural disorders;

- implementation of public awareness campaigns regarding issues;

- introduction of the care of employers for people with disabilities as a value or quality standard/excellence of the company.

4. Key learning

4.1. Level of agreement concerning the most efficient/effective practise

Members of national working group discussed different areas of great influence on effective mental health promotion at worksite. Assessment of these areas can be recapitulated as follows:

- **legislative framework:** The Mental Health Act introduced new possibilities for comprehensive and intersectoral care for active population, but the concrete programme and activities are still to be defined by special sublaw (resolution on national programme on mental health) which is still in the process of acceptance. The renewed Health and Safety at Work Act brings into force health promotion at worksite as employers' obligation. However the health promotion at worksites is still not a unique and standardized concept. According to the Act the guidelines will be prepared by the MoH. Mobbing (including measures and activities for prevention) is adequately defined by the Employment Relationship Act and Health and Safety at Work Act.

- **awareness/understanding (stigma):** In Slovenia mental disordes are still excessively connected with stigmatisation – especially at worksites. People with mental disorders have troubles with their employability, easier loss of their jobs and are frequent victims of workplace bullying. Professional assistance and education of employers, changes in working environment and organisation of work as typical health promotion intervention are of greatest importance.

- **business cases and the need for dissemination of good practice in enterprises:** Recent evaluations of different trainings and seminars reveal the fact that employers would like to be informed about models of good practice. In Slovenia there are several – for example those identified within the project called Mental health promotion at worksite (MentHealthWork): in DOMEL (company in Železniki) and HEALTH RESORTS (Radenci).

- **mental health system:** The most widespread internal activity in enterprises in Slovenia are different (educational) courses about stress at worksites where the responsibility for mental health is too much imposed to individuals and their individual stress management. Only few interventions are devoted to working environment which should support mental health of workers. Only rarely do employers have a system to support workers with mental problems or to support workers who are back at work after long sickness leave due to mental problems. Again the understanding of health promotion and the standardised concepts for employers are of great importance. This refers to the role and knowledge of occupational medicine practitioners, too. Changes in the traditional functions and role of medical occupational medicine specialists and occupational psychologists in working ability surveillance and assessment of psycho-social risks of the worksites are needed, too.

- business cases and the need for dissemination of good practice in enterprises: recent evaluations of different health education and health promotion approaches expose the fact that employers want exchange known best practises in these fields overall. In Slovenia there are some utility models of good practise – for example mental health promotion at worksite (MentHealthWork) in DOMEL (company in Železniki) and HEALTH RESORTS (spa in Radenci).

- **mental health system:** The most widespread internal activity in enterprises in Slovenia are different (educational) courses about the stress at worksite where the responsibility for mental health is too much imposed to individuals and their individual stress management. Only few interventions are devoted to working environment which should support mental health of workers. Only rarely do employers have a system to support workers with mental problems or to support workers who are back at work after long sickness leave due to mental problems. Again the understanding of health promotion and the standardised concepts for employers are of great importance. This refers to the role and knowledge of occupational medicine practitioners, too. Changes in the traditional functions and role of occupational medicine specialists and occupational psychologists in working ability surveillance and assessment of psycho-social risks of the worksites are needed, too.

- **implementation of OSH standards in relation to mental demands:** New legislation demands from employers to add new assessments of psychosocial risks to traditional safety statements. However in Slovenia these assessments are still "too technical" (prepared mostly by safety engineers). In revisions of risk assessments psychosocial risks are identified and evaluated. It is important that new risk assessment tools or applications (in Slovenia there are a lot of efforts to adapt and promote OIRA application for small enterprises) should include comprehensive understanding of mental health promotion interventions.

- **cooperation between health and labour sector:** In Slovenia the cooperation between health and labour sector is not optimal. This refers to the processes of drawing-up legislative changes, organisation and financing of activities, where both sectors should closely cooperate. Partially certain activities in the field of workplace health promotion are taken over by the MoLFSAEQ, the Labour Inspectorate of the Republic of Slovenia and the Health Insurance Institute of Slovenia. A good example of cooperation is also the National Network for cooperation with European Agency for Health and Safety at Work (EU-OSHA) which is coordinated by MoLFSAEQ, i.e. the Slovenian Focal Point of the EU-OSHA.

- **knowledge development:** The knowledge and concept of workplace health promotion has been intensively developed and expanded only in last decade. The most comprehensive educational programme is implemented within "Fit for work programme" (performed by Clinical Institute of Occupational, Traffic and Sports medicine of Ljubljana University Medical Centre). It is expected that the new legislative obligation of employers to perform health promotion at worksite will represent strong push to further development. For example in the year 2012 new educational programme for worksite health promotion within the specialisation of occupational medicine was prepared (in cooperation with international experts). Workplace health promotion is also a part of future training for nurses specialized in occupational health.

4.2. Level of agreement concerning the most relevant needs for improvement

At the second meeting in October 2013, members of the national working groups harmonized specific positions on the assessment of the situation and development prospects and adopted final recommendations for further actions in the field of health promotion, which cover major challenges for further development in both areas, which were the subject of the SWOT analysis (measures to promote mental health and support for the already affected workers).
Final recommendations were as follows:

1. In Slovenia, it is necessary to establish a uniform intersectoral development strategy (national programme) regarding promotion of mental health at workplaces, which should:

- result from a detailed situation analysis regarding behavioural and mental disorders in the workplace and regarding implementation of existing programmes and projects for the promotion of mental health in the workplace;

- identify recommendations or solutions for various stakeholders – for general measures of promotion of mental health in the workplace and measures to support workers, who are already affected by behavioural and mental health, whereby it is necessary to strengthen the role of the occupational medicine provider and the role of the coordinator of activities in returning workers to the workplace;

- include protocols of mandatory inter-ministerial cooperation for individual measures and activities;

- provide trans-sectoral harmonized financial resources for projects, which will cover the field of mental health in the workplace and which will enable concrete programmes of promotion of mental health in companies;

- enable a continuous (analytic or research) monitoring of the implementation of the objectives.

In order to ensure specific grounds and decision-making to establish intersectoral development strategy, all relevant parliamentary committees and governmental bodies should be informed with the present situation in the field of mental health at workplaces and with labour issues and adapted employment for people with mental disorders.

In the preparation of the programme representatives of all key stakeholders in the field of health promotion at workplaces should take part. National working group should be nominated by the Government.

2. In Slovenia certain effective programmes of promotion of (mental) health in the workplace are already being implemented. To ensure such programmes would not exist only in a few certain companies, it is necessary to establish a system for their systematic distribution among all economic operators with an appropriate taxation treatment of financial contributions of employers and the introduction of differentiated contribution rates for employers.

3. In Slovenia, it is necessary to carry out a relevant national campaign or systematic activities of information and education, which will sensitize and train various stakeholders, particularly employers, for the issues and the importance of promoting mental health in the workplace and measures for workers who are already affected by behavioural and mental disorders.

4. Because the government in Slovenia does not have a specially designed development vision regarding health of the (active) population, it is necessary to include measures for preserving (mental) health of workers ("survivors" and dismissed workers) into measures and activities for restructuring or restart of the economy.

5. Regarding better care for the already affected workers, the following measures are essential:

- establishment of a highly adaptable system of patients returning to the work process after a long sick leave,

- establishment of flexible options to carry out works for people with disabilities (work at home, work on the computer etc.

- introduction of the care of employers for people with disabilities as a value or quality standard/excellence of the company

At the second meeting, members of the national working groups also unified views regarding the selection of models of good practice in the field of mental health in Slovenia, which are promising for dissemination in both domestic and international environment. Members of the national working group got acquainted with specific programmes and projects of promotion of (mental) health29 , implemented in workplaces in Slovenia. Those are the following programmes and projects:

- programmes and projects co-financed by the Ministry of Labour, Family, Social Affairs and Equal Opportunites of the European Social Fund (public tender for co-funding of projects of social partners in improving the working environment, 2010 – 2012)

- programmes and projects by the Health Insurance Institute of Slovenia (public tender for co-financing of programmes and projects for the period 2011/2012)

- programmes and projects carried out by various institutions for public health in the promotion of (mental) health in the workplace

- programmes and projects carried out by various institutions for public health in the field of mental health for the general population

- programmes and projects carried out in the field of social entrepreneurship, so called cooperatives

Information compiled from the Statistical Yearbook of the Republic of Croatia 2012 (bilingual; Croatian and English)
http://www.dzs.hr/Hrv_Eng/ljetopis/2012/sljh2012.pdf

Information compiled from the Croatian Health Service Yearbook 2012 (bilingual; Croatian and English)
http://www.hzjz.hr/publikacije/00_2012_WEB.pdf

Information compiled from the Statistical Yearbook of the Republic of Croatia 2012 (bilingual; Croatian and English)
http://www.dzs.hr/Hrv_Eng/ljetopis/2012/sljh2012.pdf

Information compiled from the Croatian Health Service Yearbook 2012 (bilingual; Croatian and English)
http://www.hzjz.hr/publikacije/00_2012_WEB.pdf

Sectors to which individual stakeholders belong are marked by text in italics under each point.

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[29] For this purpose, a special list or review of programmes and projects of promotion of health in the workplace was prepared and is available in Supplemenmt 4 of this document.